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ABSTRACT

A report of vocational rehabilitation planning is introduced by the history and principles of rehabilitation, a discussion of legal provisions, sources of funds, planning objectives, and project population and organization. Demographic information, statewide recommendations, and descriptions of state institutions and agencies are included along with the methods used for estimating the potential of inmates. Additional information concerns the disabled and handicapped in the state, the five planning regions, the rehabilitation facilities (treatment centers, halfway houses, and sheltered workshops), and project studies (involving physicians, nurses, professional personnel, school personnel, and a closed caseload study). Related programs on the aging, correctional rehabilitation, economic opportunity, facilities and workshops, military rejectees, public assistance, the rural disabled, social security, workmen's compensation, voluntary organizations, and coordination of programs are also discussed. Five appendixes and a summary of recommendations are provided. (JM)

ED034339

Final Report

MONTANA

STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION

EC004653E

ED034339

FINAL REPORT

COMPREHENSIVE STATEWIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

MONTANA

Division of Vocational Rehabilitation
507 Power Block
Helena, Montana 59601

T. J. Witham
Project Director

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T. J. WITHAM
PROJECT DIRECTOR

September 27, 1968

TO: The Honorable Tim Babcock

It is with pleasure that the final report of the Governor's Policy Board of the Statewide Planning Project for Vocational Rehabilitation is presented to you and to the citizens of Montana.

This report represents the efforts of hundreds of citizens who have generously given of their time and energies during the past 21 months so that the disabled children and adults of our State can fully share the opportunities that other Montanans enjoy.

Rehabilitation presents both a challenge and a promise. The challenge can be met if the governmental and voluntary agencies coordinate their efforts and their resources in the years ahead. The promise will be fulfilled when each person, disabled due to physical, mental, or other conditions, becomes a socially and economically contributing member of our society.

Very respectfully submitted,

Wm C. Walterskirchen
WM. C. WALTERSKIRCHEN
Chairman, Policy Board

ACKNOWLEDGMENT

Appreciation is expressed to the hundreds of interested Montanans who have participated in the Project and given so willingly of their time and energies so that adequate programs for all disabled will be available in the coming years.

T.J.W.

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CHAPTER I

INTRODUCTION

Principles of Rehabilitation

The productive efforts of all citizens are required in any society that is concerned with the economic, social, and personal well-being of its members. Work, traditionally an integral part of the culture of America, provides a means of satisfying many basic needs. It furnishes the necessary subsistence to the individual and his family, while enabling psychological and social needs to find expression in a creative manner. The dependence of unproductive individuals tends to debilitate not only the nation but the individual himself. Disability can result in costly dependence, but rehabilitation offers hope through the reduction or elimination of resultant conditions of dependency. The ethical and religious ideals of the Judeo-Christian faiths in this country have also influenced the philosophy of rehabilitation. As a consequence we find the combination of work orientation and humanitarian principles in a social service program. These are the basic underlying concepts upon which rehabilitation programs have been developed in this country.

Disabled persons frequently present unique problems which require a wide array of professional services and facilities to overcome; these are services which the average disabled person is ill-equipped to obtain without help. Specialized programs and agencies are needed if the disabled are not to be neglected in programs designed to serve the general population.

Rehabilitation has been defined in many ways, and each practitioner tends to accept the definition most descriptive of his function. This lack of a standard definition contributes to the segmentation and fragmentation of programs. In its broadest, most practical sense, rehabilitation is a philosophy of the treatment of individuals, and consists of the application of certain principles in the achievement of specific goals.

The first principle is that the individual must be treated as a total being rather than a problem defined solely in physical, social, economic, or emotional terms. The second principle is the recognition of the worth of the individual. The third is that each human being has a right to those services which will enable him to fulfill his greatest potential, and the fourth is that the community has a responsibility to see that necessary services are available to rehabilitate the individual.[1]

Rehabilitation is not, therefore, the sole responsibility or prerogative of any one agency or group, but is dependent upon the coordinated contributions of many.

The State-Federal Vocational Rehabilitation program is the legal expression of these principles.

History of Rehabilitation

The early history of the vocational rehabilitation movement in the United States was begun with the work of private agencies. In 1918, the first national interest was stimulated with passage of the Smith-Sears Act which provided for the vocational rehabilitation of disabled veterans. The Vocational Rehabilitation Act of 1920 provided for a rehabilitation program for civilians.

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[1] Armstrong, K. S., "What Constitutes Rehabilitation?", Rehabilitation 28:5-9, January-March, 1959.

A Vocational Rehabilitation program began in Montana in 1921. These first programs were oriented toward vocational training of the physically handicapped. Since that time the programs have expanded in scope to include comprehensive diagnostic services, counseling, physical restoration, training, training supplies, maintenance, placement, tools and equipment, and initial stocks of supplies for those in self-employment. Almost any service which makes a substantial contribution to the individual's rehabilitation can now be provided under the broadened program of the State Vocational Rehabilitation agency.

The State-Federal Vocational Rehabilitation program continues to reflect the changing needs of the disabled individual and his relationship to a society which is becoming increasingly complex, but which offers more hope to the disabled than at any time in the past.

"Only one Federal program approaches in concept the ideal of an integrated manpower program: The Vocational Rehabilitation program. Like anything else in the real world, it falls far short in practice of what it is designed to accomplish. Nevertheless, it is worth examining as a model of a single program designed to provide the full range of services required by those facing handicaps in labor market competition."[2]

Reaffirmation of Vocational Rehabilitation programs as a practical alternative to a system of doles and dependency is reflected in the major reorganization of the Federal Department of Health, Education, and Welfare and the resultant amalgamation of five existing agencies into the new Social and Rehabilitation Service.

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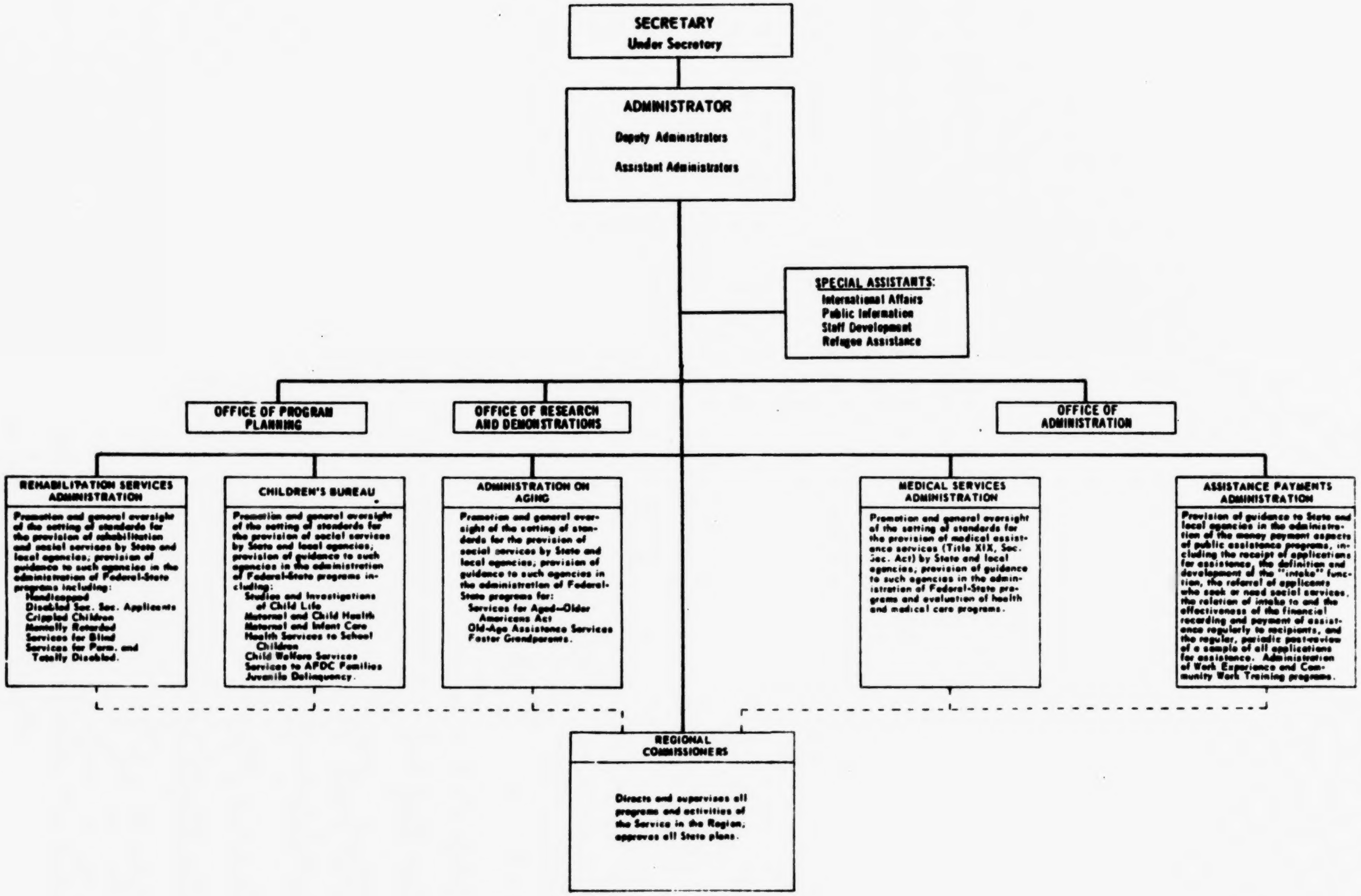
[2] Robson, R. T. and Mangum, G. L., "Coordination Among Federal Manpower Programs," _Critical Issues in Employment Policy_, p. 127, Princeton University, 1966.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social and Rehabilitation Service


SECRETARY
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ADMINISTRATOR
Deputy Administrators
Assistant Administrators
SPECIAL ASSISTANTS:
International Affairs
Public Information
Staff Development
Refugee Assistance
OFFICE OF PROGRAM PLANNING
OFFICE OF RESEARCH AND DEMONSTRATIONS
OFFICE OF ADMINISTRATION

REHABILITATION SERVICES ADMINISTRATION

Promotion and general oversight of the setting of standards for the provision of rehabilitation and social services by State and local agencies; provision of guidance to such agencies in the administration of Federal-State programs including:
- Handicapped
- Disabled Soc. Sec. Applicants
- Crippled Children
- Mentally Retarded
- Services for Blind
- Services for Perm. and Totally Disabled.

CHILDREN'S BUREAU

Promotion and general oversight of the setting of standards for the provision of social services by State and local agencies; provision of guidance to such agencies in the administration of Federal-State programs including:
- Studies and Investigations of Child Life
- Maternal and Child Health
- Maternal and Infant Care
- Health Services to School Children
- Child Welfare Services
- Services to AFDC Families
- Juvenile Delinquency.

ADMINISTRATION ON AGING

Promotion and general oversight of the setting of standards for the provision of social services by State and local agencies; provision of guidance to such agencies in the administration of Federal-State programs for:
- Services for Aged—Older Americans Act
- Old-Age Assistance Services
- Foster Grandparents.

MEDICAL SERVICES ADMINISTRATION

Promotion and general oversight of the setting of standards for the provision of medical assistance services (Title XIX, Soc. Sec. Act) by State and local agencies, provision of guidance to such agencies in the administration of Federal-State programs and evaluation of health and medical care programs.

ASSISTANCE PAYMENTS ADMINISTRATION

Provision of guidance to State and local agencies in the administration of the money payment aspects of public assistance programs, including the receipt of applications for assistance, the definition and development of the "intake" function, the referral of applicants who seek or need social services, the relation of intake to and the effectiveness of the financial recording and payment of assistance regularly to recipients, and the regular, periodic post-review of a sample of all applications for assistance. Administration of Work Experience and Community Work Training programs.

REGIONAL COMMISSIONERS

Directs and supervises all programs and activities of the Service in the Region; approves all State plans.

This precedent has great implications for the future development of the involved agencies and should, when fully implemented, result in better, more adequately coordinated services for the individual.

Legal Authority and Responsibility of Montana Division of Vocational Rehabilitation and Division of Blind Services

The legal responsibility for vocational rehabilitation of the disabled in Montana is vested in two agencies: The Division of Vocational Rehabilitation under the State Board of Education[3] (Vocational Rehabilitation Act of Montana, Chapter 8, Title 41, Revised Codes of Montana, 1947), and the Division of Blind Services under the Department of Public Welfare[4] (Public Welfare Laws, Chapter 14, Title 41, Revised Codes of Montana, 1947).

The law states that these agencies will provide vocational rehabilitation services to any individual who, because of a physical or mental condition, has an employment handicap.

Under Public Law 333 of the 89th Congress, the regulations issued by the Secretary of Health, Education, and Welfare pursuant thereto, and related state vocational rehabilitation legislation, the state vocational rehabilitation agencies have the following responsibilities:[5]

1. _The administration and supervision of a program of vocational rehabilitation services directly to the nation's physically and mentally handicapped youth and adults_. Rehabilitation services include the provision,

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[3] See Appendix A.

[4] _Ibid_.

[5] Council of State Administrators of Vocational Rehabilitation, _The State-Federal Vocational Rehabilitation Program Looks to the Future - A Statement of Mission and Goals_, pp. 4-6.

whenever appropriate, of any or all of the following services: diagnosis, physical restoration, counseling, training and related services, and any of the services listed above that are appropriate for the determination of the rehabilitation potential of a handicapped individual over an extended period of time. This program of direct services is the heart of the responsibility of the state vocational rehabilitation agencies.

2. Development of a statewide plan for the provision of comprehensive, high-quality vocational rehabilitation services to all who need them. This includes the development of a state plan for an adequate network of rehabilitation facilities and workshops to serve handicapped people. Although the general statewide planning effort is a state responsibility, rather than a vocational rehabilitation agency responsibility, the agency has been given prime responsibility for leadership in such studies in most states.

3. Working with other public and voluntary agencies and local communities to establish, staff, and operate workshops and rehabilitation facilities. A related responsibility is to act on applications of local communities for federal funds to support rehabilitation facility projects.

4. Providing consultative services to workshops in the development of workshop improvement and technical service projects and recommending the approval of such projects to the Secretary of Health, Education, and Welfare.

5. Developing contracts with, and providing consultative services to, workshops and rehabilitation facilities engaged in training programs supported by federal training grants and allowances to individuals.

6. Conducting research and demonstration activities and providing consultative services to community organizations developing research and demonstration projects and expansion programs. A related responsibility

is to act on applications for federal financial support for such projects when they involve services directly to handicapped people.

7. Making certification to the Wage and Hour Division of the United States Department of Labor of individuals who are not capable of open employment but are capable of some production and making certification to the Department of individuals that are undergoing evaluation and training programs in workshops.

8. Working with the United States Department of Labor and the United States Employment Service in the provision of diagnostic services and assistive devices to assure success of training of individuals under the Manpower Development and Training Program.

9. Developing and carrying out programs directed toward public understanding of the numbers and classes of handicapped people, their problems, the kinds of services needed to assist in their rehabilitation, and the benefits to the handicapped individuals and to society resulting from such rehabilitation.

10. Helping to create an accepting environment for handicapped people in the community and to remove or lower barriers to the full participation of handicapped people in community life.

11. Working with other public agencies with related responsibilities to assure that handicapped people for whom the various agencies share responsibility coordinate their efforts to achieve a continuum of services directed toward meeting the total needs of handicapped people. The rehabilitation agencies should initiate such cooperative programs and, where appropriate, accept responsibility for coordinating the services of the agencies involved in providing the services. This includes the authority to work with local units of government.

12. Developing and conducting innovation programs, identifying and testing new and improved methods of providing rehabilitation services to handicapped people.

13. Administering the Randolph-Sheppard Act under which business opportunities are made available to blind people in federally administered buildings.

14. Working with the Social Security Administration in making determinations of eligibility of applicants for OASDI benefits and in providing vocational rehabilitation services to beneficiaries of the Trust Fund.

TABLE 1. SOURCE OF FUNDS - DVR AND DBS

Funds for the administration of the State-Federal programs are provided on a matching basis. The State portion is provided through appropriated funds of the State Legislature, and these funds earn Federal monies at the following rates:

PROGRAM	STATE %	FEDERAL %
Basic Program	25%	75%
Establishment of Workshops and Facilities	25%	75%
Expansion Grants	10%	90%
Project Development	10%	90%
Planning Grants - Workshops and Facilities	10%	90%
Workshop Improvement	10%	90%
Training Service	10%	90%
Innovation	10% 25%	90% - First 3 years 75% - Next 2 years
Staffing Grants - Facilities	*25% *40% *55% *70%	75% - First 15 months 60% - Next 12 months 45% - Next 12 months 30% - Final 12 months Maximum 51 months
Workshop Technical Assistance		100%
Construction (Hill-Burton)		33-1/3% to 66-2/3%*̣

* Provided by recipient public or private agency

*̣ Varies

Need for Planning

Rehabilitation estimates based upon data of the State vocational rehabilitation agencies and the National Health Survey indicate that there currently exists a backlog of 3.7 million disabled in America who need and can benefit from rehabilitation services, and that an average annual increment of 500,000 or more people are added because of birth defects, disease, and accidents.

The problems facing the disabled and vocationally handicapped person in Montana are not revealed in such statistics, and more definitive information must be gathered and assessed if meaningful programs are to be developed. The programs of all social and rehabilitation oriented agencies, public or private, have evolved to meet the immediate, obvious needs within the communities. Consequently, duplication of services and programs has resulted, in certain instances, in a dearth of equally vital services needed to rehabilitate the disabled. A broader assessment of the total problem of services, manpower, facilities, social and educational opportunities, and employment is needed if the full potential of the disabled person is to be realized.

Montana, like most states, has not developed programs in accord with any plan. The total spectrum of forces which affect rehabilitation has never been considered, but development has occurred piecemeal. Public and private rehabilitation sub-systems have developed and have tended to leave the individual who seeks assistance in a quandary of conflicting programs and with minimal coordinated direction.

It is difficult enough for an individual community to plan for all the needs of its disabled. Planning on a State level is much more complex.

Functions and philosophies of agencies vary. Priorities to meet needs are difficult to assign.

Rehabilitation entails the provision of specialized services by a diverse group of complex organizations and professions. An inherent difficulty in rehabilitation is coordination of these services for the benefit of the individual. In few instances does the rehabilitation of the handicapped person occur through the use of a single service.

Change is necessary and certain, and vocational rehabilitation will not continue as it has in the past; therefore, planning for the future becomes imperative.

An overview of the many and diverse services utilized in the rehabilitation processes can be gained from the following list:

Community Social Services Related to Rehabilitation
Classified by Use in Restoration and Adjustment Processes
A Check List[6]

Types of Service	Processes of Restoration and Adjustment		
	Physical Adjustment	Social Adjustment	Vocational Adjustment
CORRECTION			
Court social services		x	
Probation		x	
Parole		x	
Protective aftercare		x	
EDUCATION			
Formal education			
elementary		x	
secondary		x	x
technical			x
higher			x
School social work		x	
School guidance		x	x
Health services	x		

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[6] Vocational Rehabilitation Administration, The Rehabilitation Agency and Community Works - A Source Book for Professional Training, pp. 115-116,

A CHECK LIST (Continued)

Types of Service	Processes of Restoration and Adjustment		
	Physical Adjustment	Social Adjustment	Vocational Adjustment
EMPLOYMENT			
Job finding			x
Employment counseling			x
Psychological testing		x	x
Vocational rehabilitation		x	x
Job engineering			x
Placement and follow-up			x
HEALTH			
Physical health (in-patient and out-patient)			
Dentistry	x		
Medicine and surgery	x		
Nursing	x	x	
Occupational therapy	x	x	x
Orthotics-Prosthetics	x		
Physical therapy	x	x	
Mobility instruction		x	x
Speech pathology and audiology	x		
Social Work			
Casework		x	
Group work		x	
Mental health			
In-patient			
Nursing		x	
Psychiatry	x	x	
Psychology		x	
Social work		x	
Therapeutic recreation		x	
Other hospital services	x	x	
Out-patient: Community mental health			
Private practice of psychiatry	x	x	
Treatment centers	x	x	x
Clinic services	x	x	
Aftercare centers		x	
PUBLIC HEALTH			
Treatment facilities and convalescent and nursing home care	x	x	

A CHECK LIST (Continued)

Types of Service	Processes of Restoration and Adjustment		
	Physical Adjustment	Social Adjustment	Vocational Adjustment
HOUSING			
Residential facilities			
Housing for those with special disabilities	x	x	
Housing for the aged	x	x	
Public facilities for use of the disabled (schools, theatres, stores, etc.)	x	x	
SOCIAL WELFARE*			
Child Welfare			
Adoption services		x	
Crippled children's services	x	x	
Foster home placement		x	
Maternal and child health services	x	x	
Protective service	x	x	
Residential treatment		x	
Homemaker and housekeeper service	x	x	
Public Assistance			
Aid to the Blind		x	
Aid to the Disabled		x	
Aid to Families with Dependent Children		x	
General Assistance		x	
Medical Assistance	x	x	
Medicaid--Title XIX	x	x	
SOCIAL INSURANCE			
Health Insurance for the Aged (Medicare)	x	x	
Old-age survivors and disability insurance		x	
Public employees retirement		x	
Railroad retirement, unemployment, and disability		x	
Temporary disability insurance		x	x
Workmen's compensation		x	

---

*In varying degrees, the services listed under "Health," are offered in conjunction with these social welfare services. Social casework or group work is usually offered in conjunction with all of them.

Objectives of Planning

The planning activities were designed to accomplish three general objectives:

1. To bring into being a well-defined picture of state resources for rehabilitating the disabled, and a clear picture of foreseeable needs.
2. To help assure an orderly growth and development with a minimum of duplication.
3. To arrive at an organized statewide plan by which all disabled persons needing rehabilitation services can receive them by 1975.

Project Population

The delineation of the population on which data was gathered presents immediate and difficult problems of definition. The primary emphasis of the Project was directed toward the individual who has traditionally formed the clientele of the Vocational Rehabilitation agencies, in addition to certain groups included under the new categories of persons who are to be extended services in accord with the Vocational Rehabilitation Amendments of 1965.

At no time was an attempt made to identify all disabled in Montana. Such an endeavor goes far beyond the intent of the Project. Disability, regardless of its nature or extent, does not in itself constitute a need for the services of Vocational Rehabilitation. The existence of a disability constitutes only one factor having relevance to the determination of need for rehabilitation. Social and economic factors, motivation, age, etc. must be considered in the assessment of whether the condition creates a handicap to employment. Therefore, the limitation of activity imposed by a physical, mental, or other condition must be reviewed in the context of other seemingly extraneous conditions if a determination as to numbers of persons who will take advantage of rehabilitation services is attempted.

Project Organization

The Governor designated the Division of Vocational Rehabilitation as the agency responsible for the conduct of the Project, as required by the Vocational Rehabilitation Act Amendments of 1965 (Public Law 89-333). This Act authorized a two-year program of grants to states to help plan for the development of comprehensive rehabilitation services in each state.

The appointment of an eleven-member Policy Board,[7] representative of broad rehabilitation interests, was completed by the Governor in December of 1966. At the first meeting of the Board, a Chairman and Co-Chairman were selected. An Executive Committee was appointed from the membership to serve as the functional unit of the Board. Selection of a Project Director was made by the end of December and he, in turn, employed an analyst and secretary.[8]

Public and private groups felt to be concerned with the disabled were selected, and they were invited to name a representative to the Citizens Advisory Committee of the Planning Project.[9]

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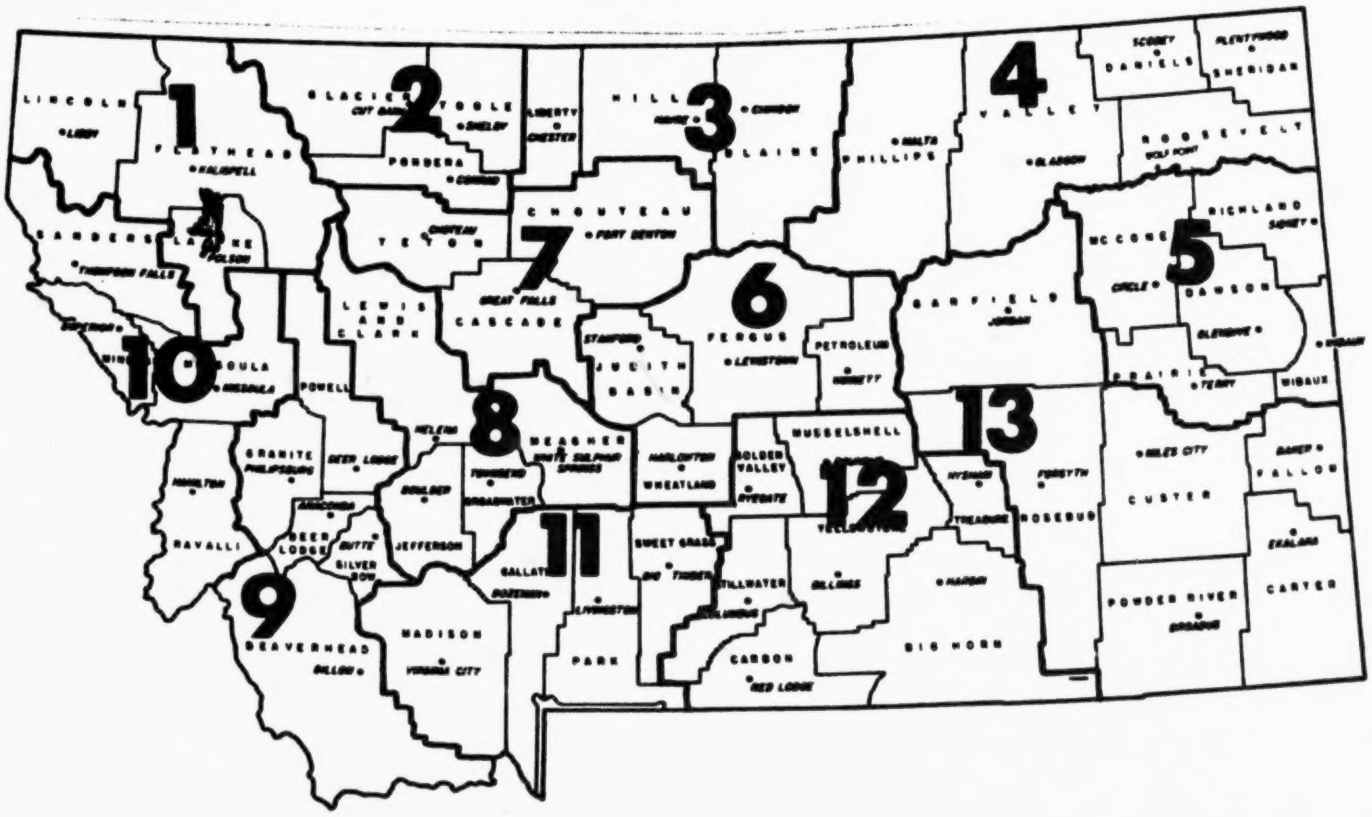
[7] See Appendix B.

[8] Ibid.

[9] Ibid.

The State was divided on the basis of the same thirteen units utilized by the Community Mental Health Planning Committee and the Montana Mental Retardation Planning Committee. These thirteen Districts were utilized to facilitate the gathering of data, and as an effort to coordinate planning and development activities.

A Chairman for each of the thirteen Districts was enlisted, and these Chairmen selected a representative from each county in their District.[10] The county representative had a major responsibility in the survey work and as a liaison with community agencies in the development of recommendations.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LIBERTY
CHESTER
HILL
HAVRE
BLAINE
PHILLIPS
MALTA
VALLEY
GLASGOW
DANIELS
SCOBEY
SHERIDAN
PLENTYWOOD
ROOSEVELT
WOLF POINT
PONDERA
CONRAD
TETON
CHOTEAU
CHOUTEAU
FORT BENTON
SANDERS
THOMPSON FALLS
LAKE
POLSON
MINERAL
SUPERIOR
MISSOULA
LEWIS AND CLARK
HELENA
CASCADE
GREAT FALLS
JUDITH BASIN
STANFORD
FERGUS
LEWISTOWN
PETROLEUM
WINNETT
GARFIELD
JORDAN
McCONE
CIRCLE
RICHLAND
SIDNEY
DAWSON
GLENDIVE
PRAIRIE
TERRY
WIBAUX
POWELL
DEER LODGE
GRANITE
PHILIPSBURG
RAVALLI
HAMILTON
ANACONDA
BUTTE
SILVER BOW
BEAVERHEAD
DILLON
MADISON
VIRGINIA CITY
JEFFERSON
BOULDER
BROADWATER
TOWNSEND
MEAGHER
WHITE SULPHUR SPRINGS
GALLATIN
BOZEMAN
PARK
LIVINGSTON
WHEATLAND
HARLOWTON
GOLDEN VALLEY
RYEGATE
SWEET GRASS
BIG TIMBER
STILLWATER
COLUMBUS
CARBON
RED LODGE
MUSSELSHELL
YELLOWSTONE
BILLINGS
BIG HORN
HARDIN
TREASURE
HYSHAM
ROSEBUD
FORSYTH
CUSTER
MILES CITY
POWDER RIVER
BROADUS
FALLON
BAKER
CARTER
EKALAKA

MAP 1. STATEWIDE PLANNING DISTRICTS

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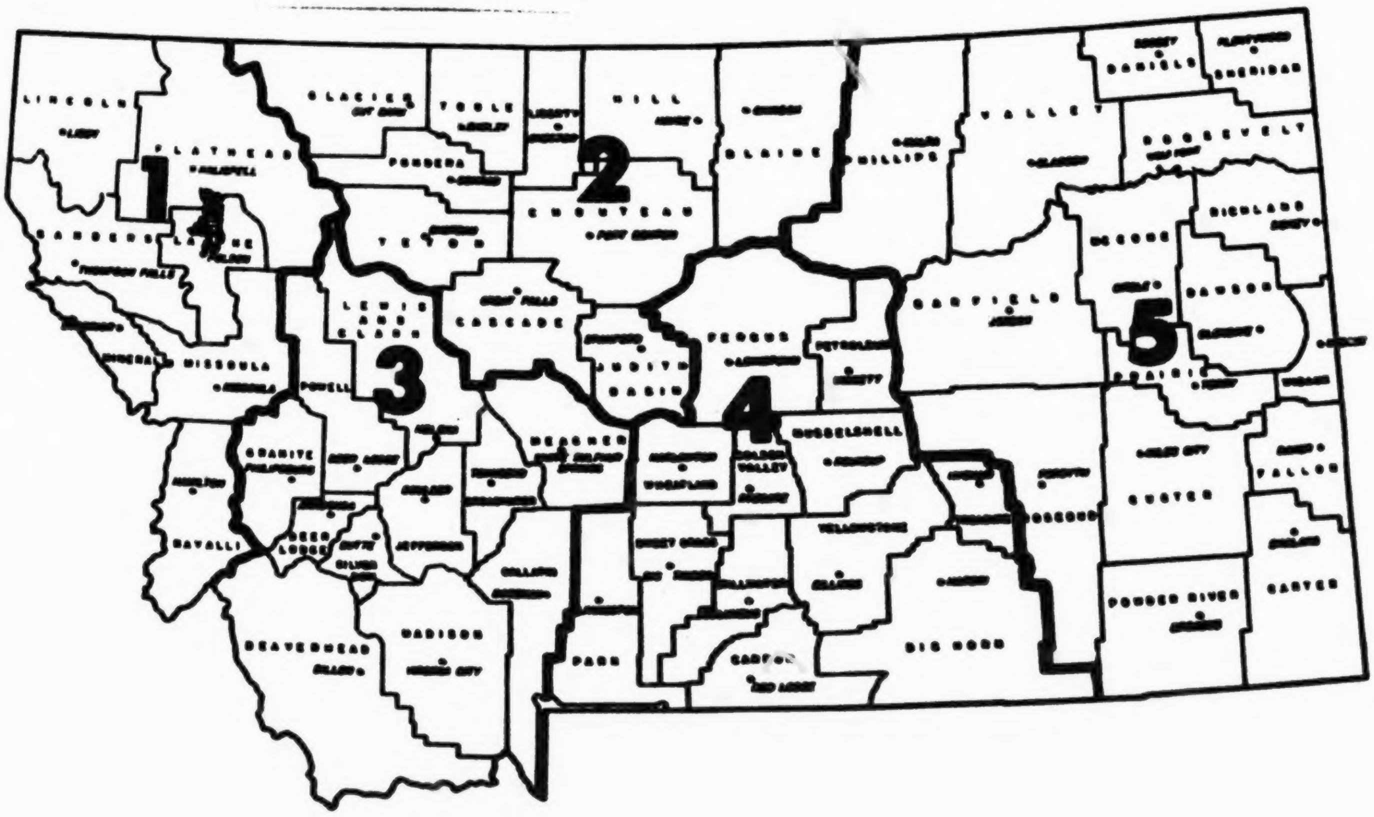
[10] See Appendix B.

Ultimately, the thirteen Districts were reorganized into the same five Regions as utilized by the two preceding study committees and the Division of Hospital Facilities of the State Department of Health.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MISSOULA
POWELL
GRANITE
RAVALLI
JEFFERSON
MADISON
BEAVERHEAD
PARK
BIG HORN
CUSTER
CARTER
POWDER RIVER

MAP 2. STATEWIDE PLANNING REGIONS

This basic structure was supplemented later in the Project through the addition of two special sub-committees to the Policy Board: the Workshops and Facilities Sub-Committee,[11] which also served as a committee to the Workshops and Facilities Project of the Division of Vocational Rehabilitation, and the Architectural Barriers Sub-Committee.[12] The Sub-Committee on Workshops and Facilities was composed of individuals currently engaged or demonstrating strong interest in rehabilitation facilities. The Barriers

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[11] See Appendix B.

[12] Ibid.

Sub-Committee was geographically representative and was constituted to study the problems of physical barriers to the disabled in buildings.

This report, then, is the result of a twenty-four month Project initiated December 1, 1966 and concluded November 30, 1968. It represents the dedicated efforts of hundreds of Montanans who have given freely of their time so that the disabled child and adult can be better served by the public and private agencies in the State.

CHAPTER II

DEMOGRAPHIC INFORMATION

Montana is the fourth largest state in land area of the United States. It is bounded on the north by Canada, on the east by North Dakota and South Dakota, on the south by Wyoming, and on the south and west by Idaho.

The extreme length of the state, east to west, is about 550 miles, and the greatest width is approximately 325 miles, north to south. The total distance along the boundary is 1943 miles. Montana is more than three times the size of Pennsylvania. The total area is 147,138 square miles, of which 145,878 square miles are land area.

As of June, 1964, 29.56% of this land was federally owned, 5.63% was Federal Trust Indian land, 5.70% was state owned, and 59.02% was privately owned.[1]

In 1960, Montana had a population of 674,767.[2] The average population density was 4.6 persons per square mile compared to the national average of 50.5, excluding Alaska and Hawaii. Just two states were more sparsely populated, Wyoming with 3.4 persons per square mile and Nevada with 2.6 persons per square mile.

In the ten years prior to 1960, the population increased by 14.2% compared to a national average of 18.5%. Growth in the years from 1960 to 1970 is projected at the rate of 9.9%.

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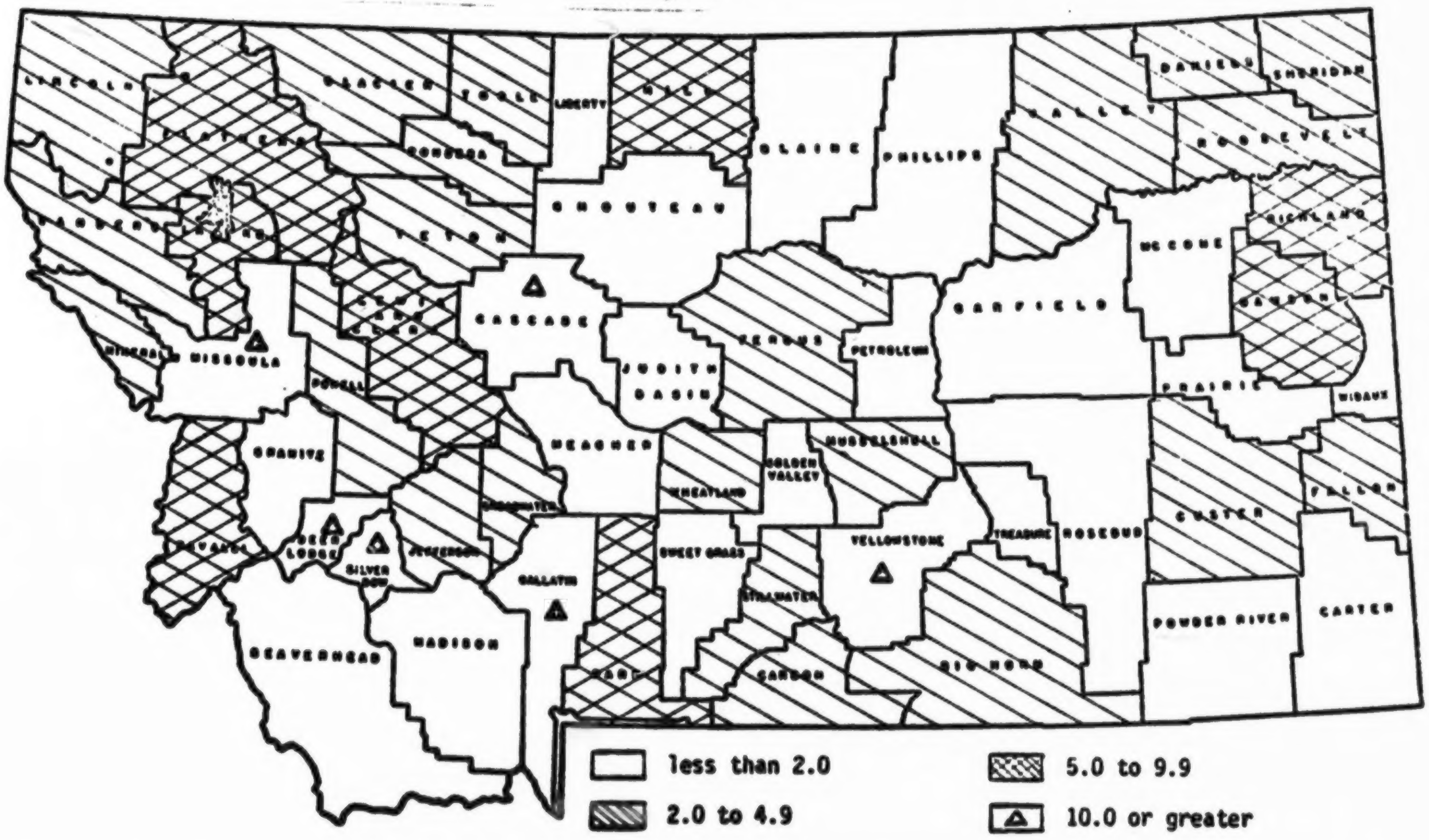
[1] Department of Planning and Economic Development, First Bank Stock Corporation, Montana Statistical Review, p. 27.

[2] Ibid., p. 35.

MAP 3. NUMBER OF PERSONS PER SQUARE MILE* MONTANA COUNTIES

1960


LINCOLN
GLACIER
TOOLE
LIBERTY
HILL
DANIELS
SHERIDAN
VALLEY
ROOSEVELT
FLATHEAD
PONDERA
BLAINE
PHILLIPS
SANDERS
LAKE
TETON
CHOUTEAU
RICHLAND
MC CONE
CASCADE
LEWIS AND CLARK
GARFIELD
DAWSON
MINERAL
MISSOULA
FERGUS
PETROLEUM
JUDITH BASIN
POWELL
PRAIRIE
WIBAUX
GRANITE
MEAGHER
MUSSELSHELL
GOLDEN VALLEY
WHEATLAND
FALLON
BROADWATER
RAVALLI
DEER LODGE
SILVER BOW
JEFFERSON
YELLOWSTONE
TREASURE
ROSEBUD
CUSTER
SWEET GRASS
GALLATIN
STILLWATER
POWDER RIVER
CARTER
BEAVERHEAD
MADISON
PARK
CARBON
BIG HORN
less than 2.0
5.0 to 9.9
2.0 to 4.9
10.0 or greater

Beaverhead	1.3
Big Horn	2.0
Blaine	1.9
Broadwater	2.3
Carbon	4.0
Carter	0.8
Cascade	27.6
Chouteau	1.9
Custer	3.5
Daniels	2.6
Dawson	5.2
Deer Lodge	25.3
Fallon	2.4
Fergus	3.3
Flathead	6.4
Gallatin	10.3
Garfield	0.4
Glacier	3.9
Golden Valley	1.0
Granite	1.7
Hill	6.4
Jefferson	2.6
Judith Basin	1.6
Lake	8.7
Lewis & Clark	8.1
Liberty	1.8
Lincoln	3.4
McCone	1.3
Madison	1.5
Meagher	1.1
Mineral	2.5
Missoula	17.1
Musselshell	2.6
Park	5.0
Petroleum	0.5
Phillips	1.2
Pondera	4.7
Powder River	0.8
Powell	3.0
Prairie	1.3
Ravalli	5.2
Richland	5.1
Roosevelt	4.9
Rosebud	1.2
Sanders	2.5
Sheridan	3.8
Silver Bow	64.9
Stillwater	3.1
Sweet Grass	1.8
Teton	3.2
Toole	4.1
Treasure	1.4
Valley	3.4
Wheatland	2.1
Wibaux	1.9
Yellowstone	30.0

*Source: Montana Statistical Review

TABLE 2. POPULATION - GROWTH PROJECTIONS[*]

	1960	1970	1975
All Ages	675,000	741,000	775,000
Under 18 years	260,000	277,000	277,000
18 - 44 years	224,000	254,000	282,000
45 - 64 years	125,000	144,000	146,000
65 years and over	65,000	66,000	70,000

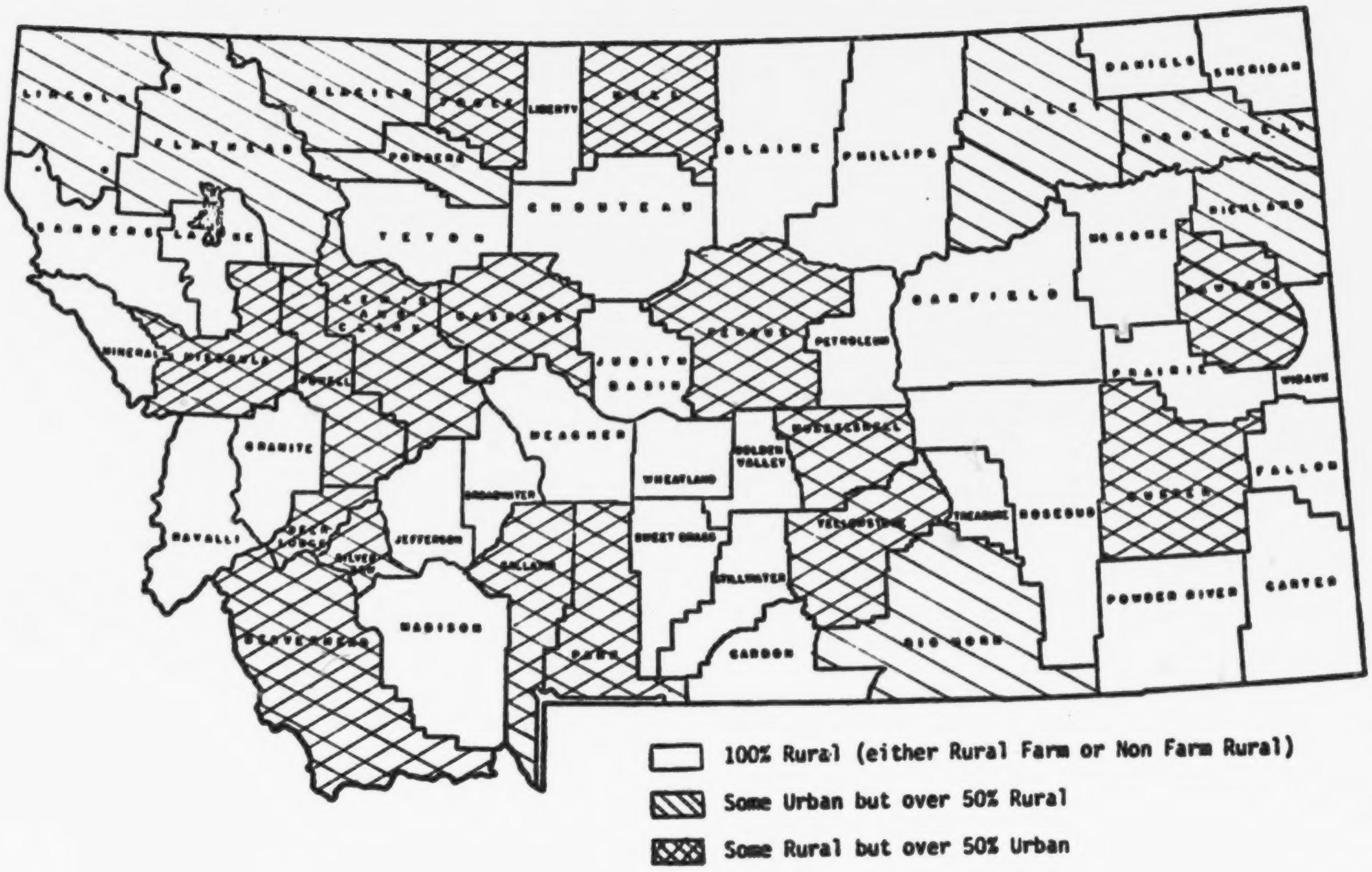
[*] Source: U. S. Department of Commerce, Bureau of the Census, Population Estimates, Series P-25, No. 326.

In 1960, 50.96% were males. This percentage is not changed materially in the projections for 1970-75, (50.6% in 1970, 50.58% in 1975). Historically, Montana has been considered a rural state. In 1870, the population was 84.9% rural. Each decade since that time, this percentage has decreased. In 1950, 56.3% of the population was considered rural, but in the succeeding ten years urban population overtook the rural, which by 1960 had dropped to 49.8%. In 1960, agriculture still employed 17.7% of the working force, contrasted with only 6.7% nationally.

The distribution and pattern of population in Montana presents not only problems of government but has implications for the development of patterns of service to meet the needs of a rural population. Only Great Falls and Billings meet the requirements of the Federal government for designation as standard metropolitan areas on the basis of population.

MAP 4. URBAN - RURAL POPULATION DISTRIBUTION*

MONTANA - 1960


□ 100% Rural (either Rural Farm or Non Farm Rural)
▧ Some Urban but over 50% Rural
▩ Some Rural but over 50% Urban

	% Urban
Beaverhead	51.3
Big Horn	27.9
Blaine	-
Broadwater	-
Carbon	-
Carter	-
Cascade	78.5
Chouteau	-
Custer	73.1
Daniels	-
Dawson	57.3
Deer Lodge	64.7
Fallon	-
Fergus	52.8
Flathead	39.8
Gallatin	51.3
Garfield	-
Glacier	39.2
Golden Valley	-
Granite	-
Hill	57.6
Jefferson	-
Judith Basin	-
Lake	-
Lewis & Clark	72.2
Liberty	-
Lincoln	22.6
McCone	-
Madison	-
Meagher	-
Mineral	-
Missoula	69.2
Musselshell	58.1
Park	62.5
Petroleum	-
Phillips	-
Pondera	34.8
Powder River	-
Powell	66.9
Prairie	-
Ravalli	-
Richland	43.5
Roosevelt	30.6
Rosebud	-
Sanders	-
Sheridan	-
Silver Bow	86.4
Stillwater	-
Sweet Grass	-
Teton	-
Toole	50.8
Treasure	-
Valley	37.5
Wheatland	-
Wibaux	-
Yellowstone	82.7

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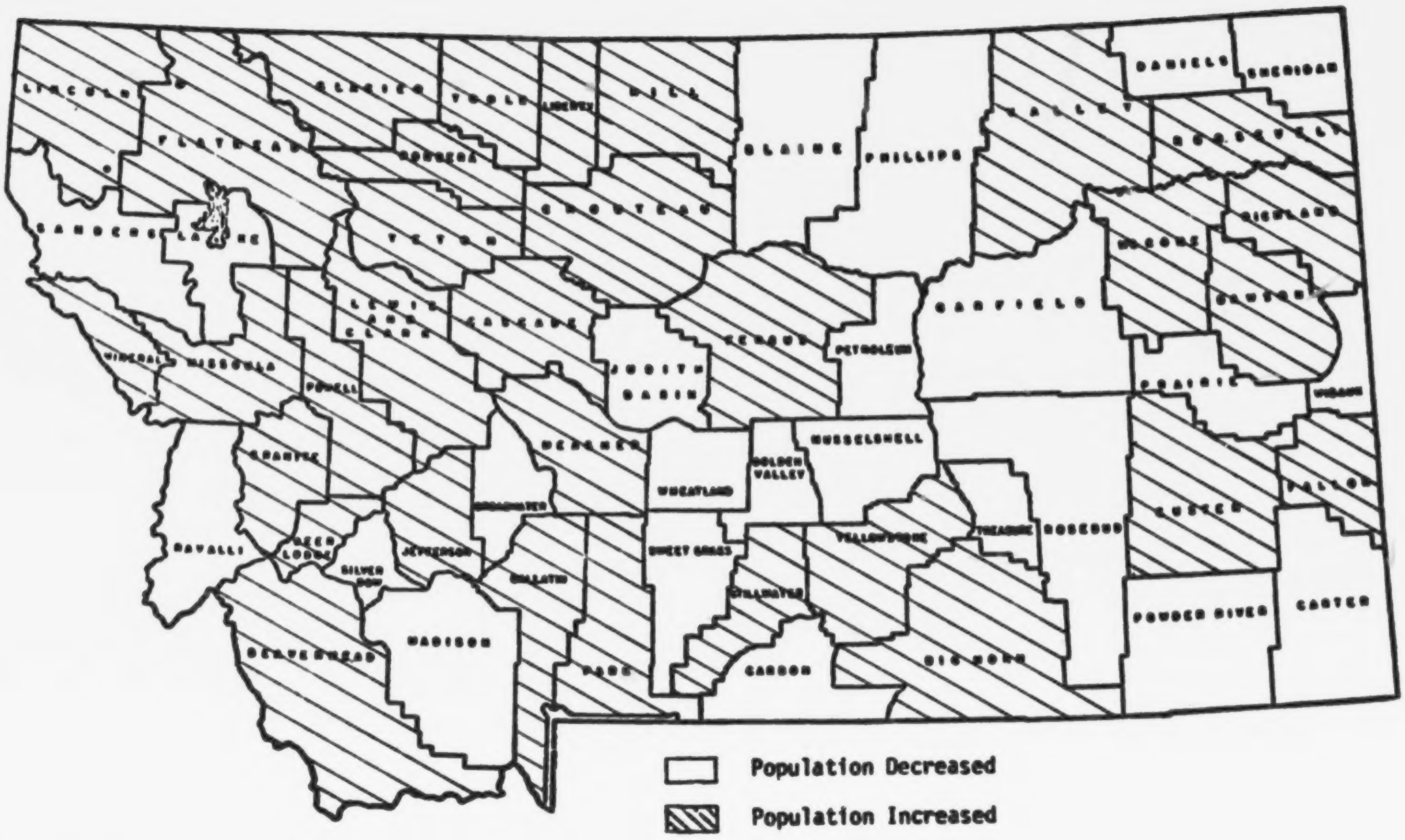
*Source: *Montana Statistical Review*.

MAP 5. MONTANA POPULATION RATE OF COUNTY INCREASE OR DECREASE#

1950 - 1960


LINCOLN
FLATHEAD
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VALLEY
DANIELS
SHERIDAN
ROOSEVELT
PONDERA
CHOUTEAU
TETON
SANDERS
LAKE
LEWIS AND CLARK
CASCADE
FERGUS
PETROLEUM
GARFIELD
McCONE
RICHLAND
DAWSON
PRAIRIE
WIBAUX
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MISSOULA
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JUDITH BASIN
MEAGHER
WHEATLAND
GOLDEN VALLEY
MUSSELSHELL
GRANITE
BROADWATER
DEER LODGE
SILVER BOW
JEFFERSON
GALLATIN
SWEET GRASS
STILLWATER
YELLOWSTONE
TREASURE
ROSEBUD
CUSTER
FALLON
RAVALLI
BEAVERHEAD
MADISON
PARK
CARBON
BIG HORN
POWDER RIVER
CARTER
Population Decreased
Population Increased

Beaverhead	7.8
Big Horn	1.9
Blaine	-5.0
Broadwater	-4.0
Carbon	-18.8
Carter	-10.9
Cascade	38.5
Chouteau	5.4
Custer	4.5
Daniels	-4.8
Dawson	35.4
Deer Lodge	12.6
Fallon	9.2
Fergus	0.0
Flathead	4.7
Gallatin	18.9
Garfield	-8.8
Glacier	19.9
Golden Valley	-10.0
Granite	8.7
Hill	30.6
Jefferson	7.1
Judith Basin	-3.6
Lake	-5.3
Lewis & Clark	14.1
Liberty	20.4
Lincoln	44.2
McCone	1.9
Madison	-13.1
Meagher	25.8
Mineral	45.9
Missoula	25.8
Musselshell	-9.6
Park	9.7
Petroleum	-12.9
Phillips	-4.9
Pondera	19.7
Powder River	-7.7
Powell	11.1
Prairie	-2.5
Ravalli	-5.8
Richland	1.3
Roosevelt	22.5
Rosebud	-5.8
Sanders	-1.5
Sheridan	-3.2
Silver Bow	-4.1
Stillwater	2.0
Sweet Grass	-9.1
Teton	0.9
Toole	15.1
Treasure	-4.1
Valley	50.4
Wheatland	-5.1
Wibaux	-11.0
Yellowstone	41.4

#Source: Montana Statistical Review

TABLE 3. MAJOR SOURCES OF INCOME - MONTANA**

1960 - 1967
(In Thousands of Dollars)

	Agriculture	Mining	Lumber	Manufacturing	Contract Construction
1960	$422,986	$178,854	$ 80,072	$205,629	$133,438
1961	379,318	183,344	79,942	212,621	194,616
1962	433,326	190,657	89,457	229,148	192,543
1963	445,435	182,018	95,076	236,230	153,962
1964	422,777	211,435	88,911	272,000	184,655
1965	471,558	228,159	102,590	284,809	218,572
1966	567,783	245,238	105,544	NA	220,409
1967**	574,981	186,162	NA	NA	268,944

**Preliminary Estimates

**Source: Montana Statistical Review

TABLE 4. NON-AGRICULTURAL EMPLOYMENT TRENDS IN MONTANA**

NUMBER OF WAGE AND SALARIED WORKERS
1964 - 1967

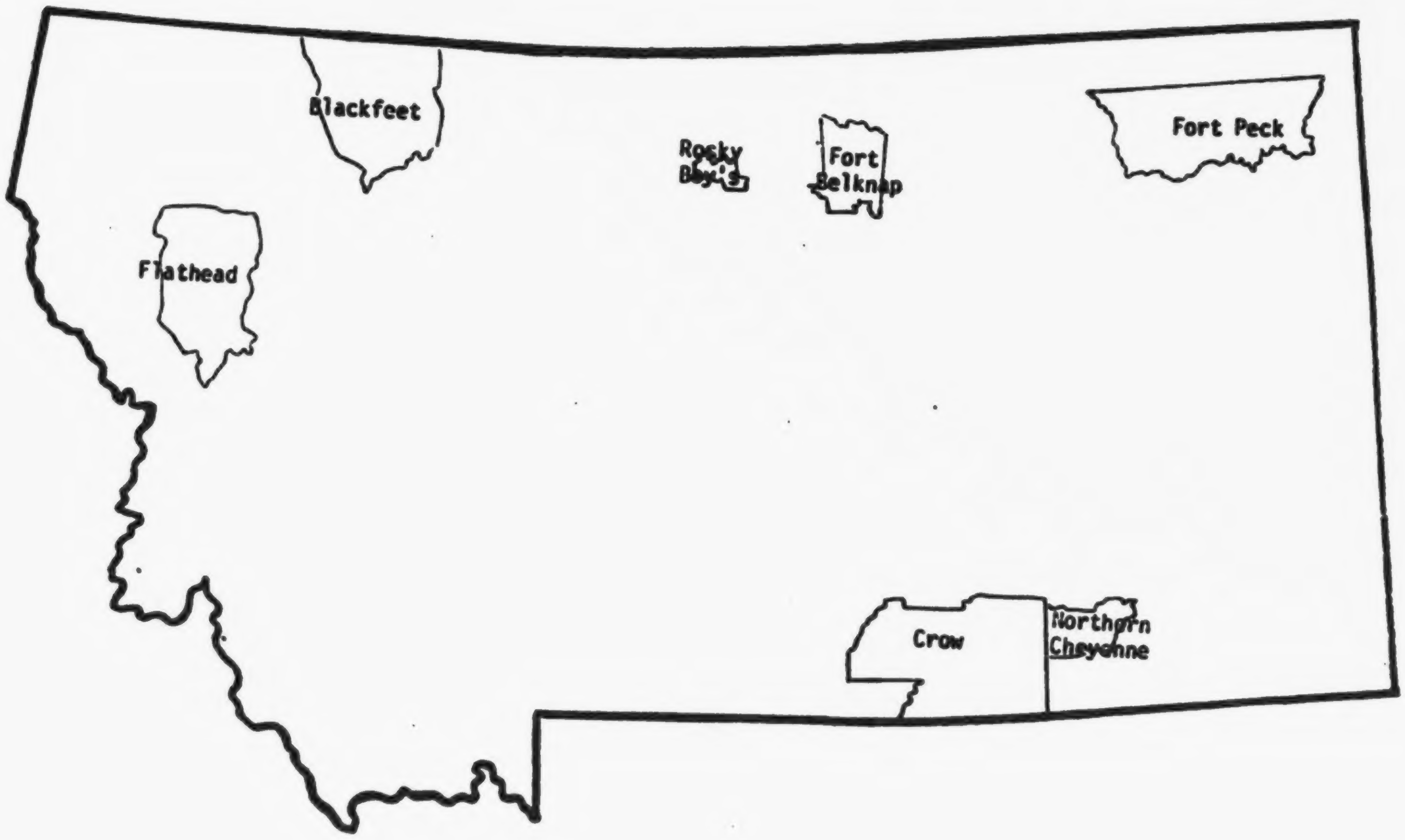
Year	Manufacturing	Mining	Contract Construction	Transportation Utilities	Trade	Finance Ins. & Real Est.	Service Misc.	Govt.
1964	21,500	7,600	11,400	17,400	41,700	6,900	25,000	44,700
1965	22,200	7,500	12,000	17,500	42,900	7,000	26,300	45,900
1966	3,000	7,600	11,600	17,700	44,200	7,200	27,300	48,100
1967##	22,500	5,600	11,600	17,800	44,700	7,300	28,600	51,800

##Preliminary Estimates

**Source: Montana Statistical Review

MAP 6. INDIAN RESERVATIONS*

LAND AREA AND NUMBER OF INHABITANTS, MONTANA


Blackfeet
Rocky Boy's
Fort Belknap
Fort Peck
Flathead
Crow
Northern Cheyenne

Reservation	Tribe	Area Sq. Miles	Indians Within Boundaries
Blackfeet	Blackfeet	1536	6,700
Crow	Crow	2460	4,690
Flathead	Salish, Kootenai	973	2,756
Fort Belknap	Gros Ventre, Assiniboine	933	1,636
Fort Peck	Sioux, Assiniboine	3125	6,728
Northern Cheyenne	Northern Cheyenne	696	2,100
Rocky Boy's	Chippewa, Cree	168	700
		9891	25,310

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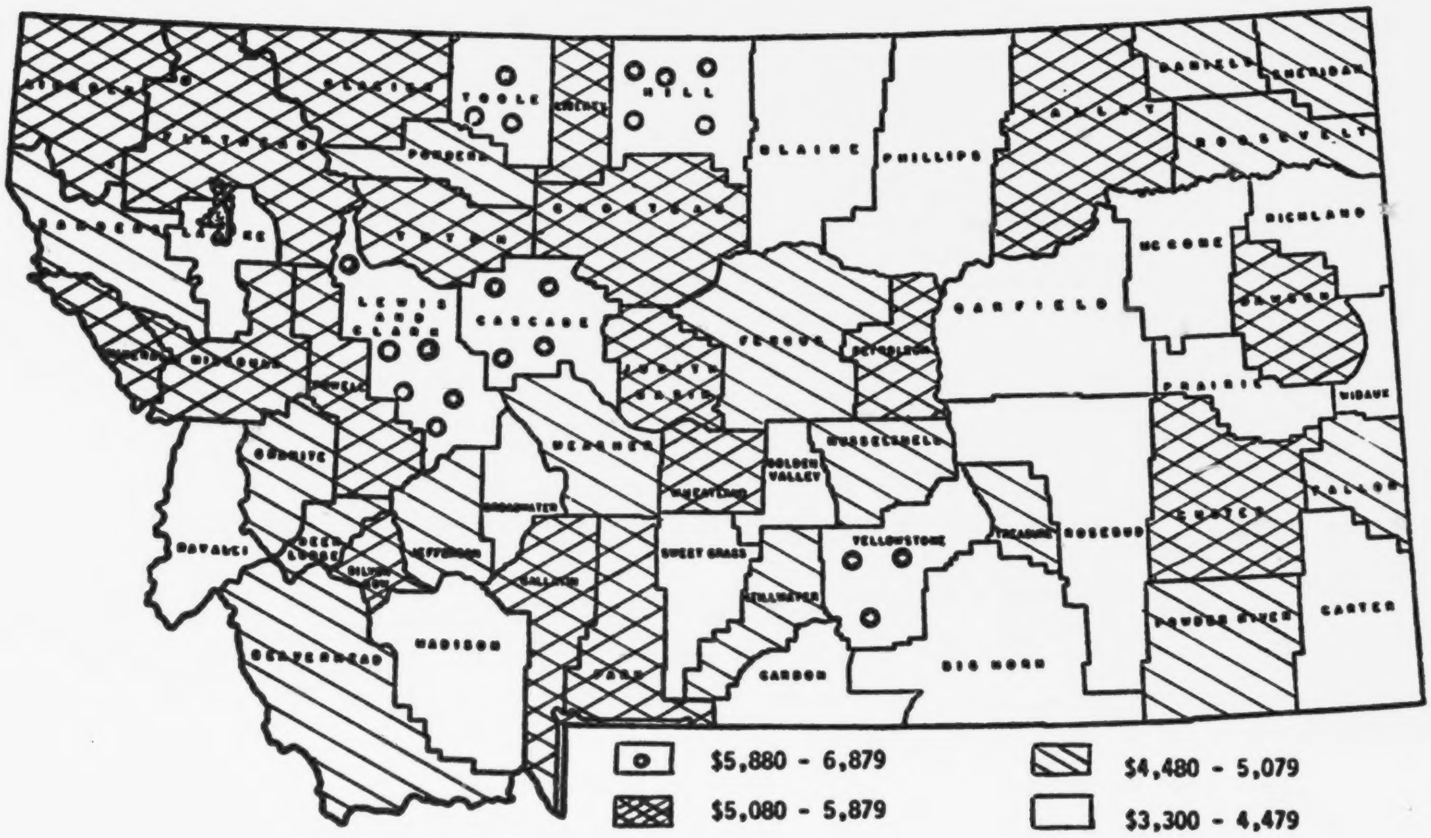
*Source: Montana Statistical Review

MAP 7. MEDIAN INCOMES OF FAMILIES* BY COUNTY

MONTANA - 1960



Beaverhead	$4998
Big Horn	4375
Blaine	4416
Broadwater	3988
Carbon	4336
Carter	4199
Cascade	6032
Chouteau	5610
Custer	5160
Daniels	4488
Dawson	5554
Deer Lodge	5022
Fallon	4694
Fergus	4992
Flathead	5392
Gallatin	5360
Garfield	3311
Glacier	5169
Golden Valley	4044
Granite	$4937
Hill	6210
Jefferson	4989
Judith Basin	5332
Lake	4183
Lewis & Clark	6461
Liberty	5858
Lincoln	5483
McCone	3915
Madison	4470
Meagher	4949
Mineral	5788
Missoula	5769
Musselshell	4927
Park	5253
Petroleum	5418
Phillips	4353
Pondera	5078
Powder River	4797
Powell	$5384
Prairie	4470
Ravalli	3819
Richland	4462
Roosevelt	4562
Rosebud	4399
Sanders	4969
Sheridan	4550
Silver Bow	5283
Stillwater	4790
Sweet Grass	4333
Teton	5267
Toole	6023
Treasure	4538
Valley	5325
Wheatland	5400
Wibaux	3431
Yellowstone	6150

*Source: Montana Statistical Review

In 1960, the median family income in Montana was $5403.00.

In 1967, Montana's per capita expenditure for Vocational Rehabilitation was $1.398 to rank it 32nd among the states. This was an increase of 40% over the preceding year when Montana spent $.997 per person.

CHAPTER III

STATEWIDE RECOMMENDATIONS

The recommendations that follow, the result of the study and efforts of hundreds of professional and lay persons in Montana, are a reflection of what they consider to be some of the most pressing problems facing the disabled person who needs services.

The recommendations emanated from the District meetings, the Citizens Advisory Committee meetings, the Workshop and Facilities and Architectural Barriers Sub-Committees, and the meetings of the Policy Board. Recommendations from the local communities, as expressed in the District meetings, were reviewed and correlated by the Advisory Committee and were approved by the Policy Board.

RECOMMENDATION 1

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES TAKE ADDITIONAL STEPS TO ASSURE THAT REHABILITATION SERVICES ARE AVAILABLE TO ALL DISABLED OF THE STATE, PARTICULARLY TO THOSE REQUIRING MORE INTENSIVE AND CONTINUOUS SERVICE. SPECIAL CONSIDERATION SHOULD BE GIVEN TO SERVICE FOR PERSONS IN THE STATE CUSTODIAL INSTITUTIONS. A REALISTIC COUNSELOR/CLIENT RATIO FOR EACH COUNSELOR IS NECESSARY.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DIVISION OF VOCATIONAL REHABILITATION DIVISION OF BLIND SERVICES LEGISLATURE

STATEMENT OF THE PROBLEM:

The initial accessibility of the disabled person to the rehabilitative services of the Division of Vocational Rehabilitation (DVR) and the Division of Blind Services (DBS) is related to the caseload of the current counseling staff and the geographic area each counselor must cover. The counseling process from inception to placement of the client in employment depends upon the establishment and maintenance of a one-to-one relationship. The nature of this relationship dictates the number of clients with whom one counselor can work effectively. This client/counselor ratio is further affected by the geographic area of each counselor and how often he can visit any community. The following table compares, on the basis of employee man-years, the caseloads in Montana with the national averages and the surrounding states.

TABLE 5. NUMBER OF EMPLOYEE MAN-YEARS: AND NUMBER OF PERSONS REHABILITATED, ACTIVE CASES SERVED, AND REFERRED CASES PROCESSED PER EMPLOYEE MAN-YEAR REGION AND AGENCY, 1967[1]

Region and agency	Employee man years	Per employee man-year		
		Persons rehabilitated	Active cases served	Referred cases processed
U.S., total ----------	13,814.4	13	41	37
General, total ----	12,621.3	13	43	39
Blind, total ------	1,193.1	6	19	17
Region VIII (Denver) -	349.2	13	46	37
General, total ----	340.8	13	47	37
Colorado -------------	155.0	14	43	42
Idaho ----------------	26.3	20	66	43
Montana --------------	24.8	25	103	75
Utah -----------------	67.4	14	58	39
Wyoming --------------	67.3	5	17	17
Blind, total ------	8.4	6	22	16
Idaho ----------------	1.3	18	44	26
Montana --------------	7.1	4	18	14

The average Division of Vocational Rehabilitation counselor caseload in Montana, as of June 1, 1968, was 249 persons, composed of 76 in referred and 173 in active status. Smaller caseloads are typical of a specialized counselor working statewide with the mentally retarded and by part-time special education-counselor personnel in school work-study programs. The Division of Blind Services counselors maintain average caseloads of 141. The average general population in the counselor service areas of DVR ranges from 28,565 to 76,282 with an average of 61,338. The DBS ranges from 64,206 to 151,283, with an average of 112,453.

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[1] Social & Rehabilitative Service, Caseload Statistics - State Vocational Rehabilitation Agencies - Fiscal Year 1967, U. S. Department of Health, Education, and Welfare, Rehabilitative Services Administration, Division of Statistics and Studies, p. 38.

The substantially greater geographic areas covered in Montana by each counselor must be considered in the determination of a suitable client/counselor ratio. The geographic area of the DVR counselors range from 4,808 to 31,752 square miles, with an average of 13,224. The DBS counselor's area ranges from 19,374 to 25,796, with an average of 24,244.

The current staffing patterns are inadequate to meet the needs of the institutional population.

The very nature of the disability which results in institutionalization requires that more frequent and intensive counseling services be available.

COMMENTS:

The existence of this problem was identified as a major deterrent to rehabilitation by 5 of the 13 districts, by the Citizens Advisory Committee, and by several of the state agency administrators whose programs utilize the services of Vocational Rehabilitation counselors. Attempts thus far to meet these demands have been directed to meet the most immediate and pressing needs, and have not been the result of overall planning. The changing nature of caseloads and the increased knowledge now available to assist in the rehabilitation of special disability groups indicates a need to utilize specialized counselors with a high degree of competency in specific disability categories. Precedent for this has been established by the utilization of a counselor with a clientele of mentally retarded, and in the past for the mentally ill. The success of the Division of Blind Services in effectively working with one disability group further demonstrates the soundness of this approach for certain groups.

The unique problems encountered in the provision of services in rural areas, specifically Montana, is clearly delineated in this statement:

> There is a special social and economic cost of space for services to people in a sparsely populated area. This cost becomes more apparent and more demanding as the level of service becomes higher and prevention and rehabilitation becomes a goal. These expenses for a sparsely populated area include the economic aspects, space costs, including also the cost of neglect and delayed services. Poorer, inadequate, and intermittent service is often associated with high space costs. Neglect, too, becomes a cost, especially when rehabilitation is thwarted.[2]

The responses of the professional persons surveyed indicate that counseling, the main forte of the rehabilitation counselor, is one of the most needed services of their clientele. These same clientele groups constitute a major source of referrals to the rehabilitative agencies. Of 378 professional respondents, 125 indicated their clientele could benefit from individual rehabilitation counseling, 121 indicated need for parental and family counseling, and 59 a need for group counseling. Similarly, of the 493 respondent nurses, 250 indicated they were aware of patients who could benefit from individual rehabilitation counseling, and 95 stated that patients could benefit from group counseling. Of the 431 physicians who completed the questionnaire, 178 were of the opinion that rehabilitation should expand services compared with 41 who felt the status quo should be maintained and 12 who felt the program should be reduced. The remainder of physicians returning the survey expressed no views on the question.[3]

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[2] Kraenzel, C. F., and Macdonald, F. H., A Study of Mental Patients in Sparsely Populated Montana and its Meaning for Federal-State Cooperation - An Interim Progress Report to Interested Citizens of Montana.

[3] Refer to Chapter VIII, Project Studies.

Specific requests for rehabilitation offices came from committees in Kalispell, Butte, Miles City, and Glasgow.

RECOMMENDATION 2

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION ADOPT AN OPERATIONAL POLICY WHICH WOULD EXTEND COUNSELING AND PRE-VOCATIONAL SERVICES TO SEVERELY DISABLED PERSONS WITHOUT REGARD TO A MINIMUM AGE, AND THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES EXTEND VOCATIONAL SERVICES TO ALL DISABLED AS RAPIDLY AS RESOURCES PERMIT.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DIVISION OF VOCATIONAL REHABILITATION DIVISION OF BLIND SERVICES DEPARTMENT OF PUBLIC INSTRUCTION LEGISLATURE

STATEMENT OF THE PROBLEM:

The federal regulations under which DVR and DBS operate do not impose any eligibility restriction for services based on age. The state plans of the two agencies were amended in 1966 to conform with federal requirements. Section 8.2(d) of these plans states: "No upper or lower age limit will be established, which will in and of itself, result in a finding of ineligibility." The DVR section does include: "Individuals accepted for service must, at time of completion of rehabilitation services, be of employable age." The ramifications of this provision are such that this section has not been adhered to because of the existing resources of staff and funds, which have been limited.

Full implementation of these sections is contingent upon the availability of resources; however, the DBS has initiated a program which works with blind children and their parents. This counseling program has proven to be an extremely valuable service.

The certainty with which one can predict the wide variety of problems which a severely disabled youngster must overcome makes it mandatory that recognition of these problems be made as early as feasible. If proper counseling and guidance are available early, many otherwise difficult or insurmountable problems could be prevented. The operational lower age limit of 16 used by DVR and 14 by DBS is also a reflection of the origins of rehabilitation as a vocationally-oriented program since entry into the labor market does not ordinarily occur before age 16. Such arbitrary limits do not recognize other important components of total rehabilitation; that is, the value of early diagnosis and treatment, prevention, and family counseling.

COMMENTS:

This recommendation was specifically cited by two districts and by several agency heads. In all districts, recognition was given to the need for providing all services as soon as possible to children exhibiting problems because of physical, emotional, or other conditions. Disabled children in the community and in the institutions do not have services necessary to effect a transition from a sheltered environment into the world of work. The 11 cooperative DVR - School District Work-Study programs provide an excellent means of accomplishing this, but they are presently geared primarily to meet the needs of the educable mentally retarded. The social adjustment and work habits gained in such programs are but a part of the total spectrum of services needed.

Early counseling, physical examination, diagnostic services of a psychological and vocational nature, and restoration are some of the services that would be of substantial benefit to the retarded, the severely orthopedically handicapped, the neurologically impaired, the deaf, and the blind. Certain services of this nature are currently provided to the orthopedically handicapped by the Crippled Children's Program under the Child Health Services Division, Department of Public Health.

The development of undesirable attitudes and behavior patterns early in life is often accentuated in the case of the handicapped child. Services at an early age will prevent dropouts socially, as well as in school.

Some evidence of the nature of disability in the age group 0-17 has been gained through the survey of agencies by the District Committees.[4] Forty-six percent of the total number identified were in the under-17 age group, and by broad categories were grouped as follows: 1,511 mentally retarded, 710 speech problems, 685 orthopedically impaired, 530 hearing problems, 466 visual problems, and 260 identified as exhibiting delinquent behavior. These individuals, together with the many others in the community and in the institutions, would have a greater likelihood of satisfactory vocational adjustment if services were available.

The extension of counseling and pre-vocational services at an early age by the rehabilitation agency would not be a duplication of any existing service but would enhance total services to the seriously disabled child.

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[4] Refer to Chapter V, "The Disabled of Montana."

The concern for extension of VR services to the younger age groups is based on the conviction of many professionals that the impact of disability is less acute if services are available at an early age. Preventative rehabilitation can be the most effective and economical rehabilitation.

Programs have been developed in other states in recognition of the need to provide services as early as possible, particularly those of a pre-vocational or adjustive nature. A special project in Bourbon County, Kentucky of DVR and a small public school system in a rural area was conducted to initiate a training program for educable retarded youth. All regular rehabilitation services were extended to 60 students in the vocational group with an IQ range of 50-75 and with a chronological range of 16 to 21. The pre-vocational group of similar students with a chronological age range of 13 to 16 years received course work in occupational education, social relationships, and homemaking. It was concluded that 10 of the 17 students manifested improvement and 26 students were rehabilitated on a full time employment basis as a result of the program.[5]

A study of cerebral palsied youth also stressed the need for early and continuous guidance and counseling with parents, together with a program of stimulation of home and outside interests.[6] One conclusion of this project was that pre-vocational services through curriculum modification at the junior high level and a pre-vocational unit were necessary for those disabled students who would enter the special high school program.

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[5] Bourbon County School, Cooperative Efforts of Schools and Rehabilitation Service for the Mentally Retarded, Paris, Kentucky, Author 1966 - VRA Grant #1285.

[6] Elizur, A. and Elkayam, G. S., "Psychological Aspects," Cerebral Palsy in Adolescence and Adulthood, A rehabilitation Study; Medical, Social, Psychological and Vocational Aspects, 1966, Voc. Rehab. Admin. Project No. O.V.R.-1-61.

The Institute for the Crippled and Disabled found, in a project which determined the vocational potential of cerebral palsied young adults, that pre-vocational activities should be determined by vocational counselors when the clients are 10 to 12 years old.[7]

RECOMMENDATION 3

APPROPRIATIONS SHOULD BE INCREASED AT THE STATE LEVEL TO ENABLE MONTANA TO RECEIVE THE MAXIMUM FEDERAL REHABILITATION MONIES NOW AVAILABLE, BUT UNUSED, SO THAT MORE DISABLED CAN BE ADEQUATELY SERVED.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	LEGISLATURE

STATEMENT OF THE PROBLEM:

The legislature appropriates funds for the support of Vocational Rehabilitation programs. This money is matched at varying rates; however, the basic ratio is 75% federal funds and 25% state. The state rehabilitation agencies have never received the full federal matching monies available; consequently, funds that could have benefited the disabled of Montana have been diverted to other states. This is true of the basic support program as well as of those funds available, but unmatched, for the development of workshops, program expansion, rehabilitation facilities construction, and other programs. Certain funds, such as those for facility staffing grants and rehabilitation facility construction using Hill-Burton money, can be matched by private agencies and are intended to serve as a means of developing programs and facilities to meet rehabilitation needs in the private sector.

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[7] Moed, M., and Litwin, D., "The Employability of the Cerebral Palsied: A Summary of Two Related Studies," Rehabilitation Literature, 24:9:266-271, 276, September, 1963.

Programs concerned with the economic and social well-being of individuals, other than education, have traditionally received a rather insignificant portion of the state tax dollar. The competition for limited state funds to meet the many pressing needs in other areas has been intense and will undoubtedly become even more so. The costs of purchasing rehabilitation services have increased at an equal or greater rate than have other costs because of the nature of the services utilized.

Services utilized extensively are those of medical diagnosis, surgery, hospitalization and other restoration, training, and equipment. All of these services are among those reflecting the greatest increases in cost in the past several years.

While the costs of rehabilitation services are substantial, no legitimate assessment of the program expenditure can be made unless a Cost-Benefits Ratio is made. Such a study was made of rehabilitants closed in the fiscal year 1966. Only one major monetary benefit, the increased lifetime earnings of the recipients of rehabilitation services under the state-federal program, was considered. The 127,824 rehabilitated wage earners will return in earnings $30.50 for each dollar expended for rehabilitation.[8]

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[8] Vocational Rehabilitation Administration, Division of Statistics and Studies, An Exploratory Cost-Benefits Analysis of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare.

The proven effectiveness of rehabilitation as a philosophy and a program of returning dependent persons to productivity is irrefutable. Those making the choices that must be made in apportioning the tax dollar for support of public programs must be cognizant of this fact.

That Montana is receiving maximum use of the available rehabilitative dollar is substantiated by comparison with other states. Montana ranks 24th in the nation in number of rehabilitants per 100,000 and 16th in the number served per 100,000. Montana expended 2.9% of the available funds for administration compared to 4.9% nationally, and 70.1% for case services vs. 58.5% nationally. Guidance and placement costs were 26.1% vs. 26.7% nationally. The remainder was expended for small business enterprises, workshops, and facilities. That these latter categories are all proportionately less than national figures reflects the fact that workshops and facilities are not available for the severely disabled in Montana. Montana counselors rehabilitated an average 43 persons per fiscal year compared to the national average of 37, despite the gross lack of specialized facilities and the large geographic distances that each must cover.[9]

The needs of the disabled in Montana for services, programs, and facilities are great. The favorable federal matching ratio for programs makes expenditures for rehabilitation an extremely wise investment on the basis of both economic and humanitarian returns. The demands for services do not allow all programs to be effected, so priorities that consider needs and costs must be established if the maximum returns of the tax dollar are to be realized.

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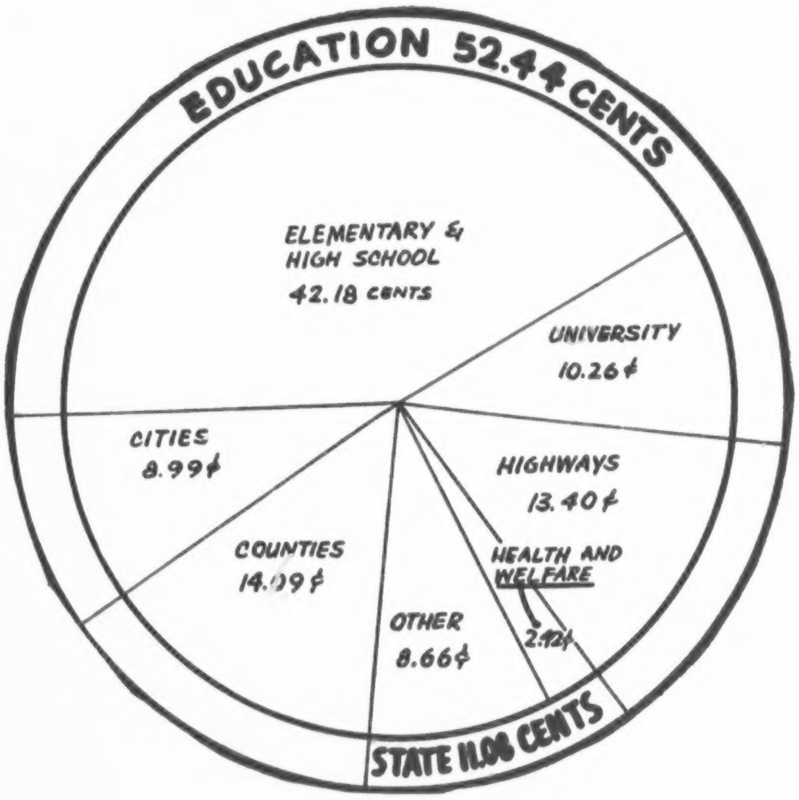
[9] Social and Rehabilitation Service, Rehabilitation Service Administration, State Vocational Rehabilitation Agency Program Data, U. S. Department of Health, Education, and Welfare.

Obviously, not all persons who are institutionalized in Montana can benefit from rehabilitation service directed to their returning to the community in a self-sustaining status. Many could be, however, if institutional rehabilitation programs were dynamically promoted. The average daily cost of maintaining a person in an unproductive, dependent status in institutions in Montana is $6.09 at the Children's Home, $5.54 at the Boulder River School, $14.08 at the Mountain View School, $11.25 at Pine Hills, $8.80 at Deer Lodge, $21.68 at Galen Hospital Unit, $4.51 at Galen Retarded Unit and $7.36 at Warm Springs State Hospital.[10]

THE 1966 TAX DOLLAR
WHERE IT GOES

ALL TAX SOURCES



*SOURCE: STATE BOARD OF EQUALIZATION

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[10] Department of Institutions, Report to the Governor, 1966-67.

Montana ranks 32nd of all states and the Virgin Islands, Guam, and Puerto Rico in the per capita expenditures for vocational rehabilitation. The per capita expenditure of state and federal funds is $1.40. The national average is $1.53.[11] The amount of Federal money allotted to Montana for Rehabilitation and the Legislative Appropriations are indicated in the following table.

TABLE 6. TOTAL DVR

FEDERAL MONEY AVAILABLE TO MONTANA AND STATE APPROPRIATIONS†

YEAR	FEDERAL MONEY AVAILABLE†	STATE MONEY NEEDED TO EARN MAXIMUM	STATE APPROPRI-ATIONS	MATCHING RATIO %	FEDERAL EARNED	DIFFERENCE BETWEEN FEDERAL ALLOCATIONS AND FEDERAL EARNED
1961	301,101.00	171,235.00	90,000.00	65.62	171,780.00	129,321.00
1962	392,853.00	228,858.00	105,523.00	62.37	174,900.00	217,953.00
1963	481,189.00	286,266.00	105,541.00	62.37	188,281.00	292,908.00
1964	670,080.00	372,205.00	130,000.00	64.08	231,915.00	438,165.00
1965	818,114.00	455,185.00	130,000.00	64.08	231,915.00	586,199.00
1966	1,261,525.00	547,672.00	160,000.00	69.54	365,279.00	896,246.00
1967	1,469,318.00	486,440.00	160,000.00	75.00	480,000.00	989,318.00
1968	1,675,272.00	552,869.00	179,900.00	75.00	539,700.00	1,135,572.00
1969	2,051,329.00	698,221.00	181,100.00	75.00	543,300.00	1,508,029.00
TOTALS	9,120,781.00	3,798,951.00	1,242,064.00		2,927,070.00	6,193,711.00

† ALL FEDERAL MONEY FOR DVR AND DBS WITH 17% ALLOCATED TO DBS.

The potential funding for rehabilitation is, therefore, contingent upon the funds appropriated by the legislature to match federal monies. However, development of any program should be based on meeting the needs. If the needs exceed the ability of the federal government to match according to a formula, the state itself as the ultimate beneficiary of rehabilitation should consider meeting human needs through additional state expenditures. It is unfortunate that in Montana where the needs of disabled people are equal to other states, and the costs of providing services are greater,[12] Montana is not receiving maximum utilization of the financial revenues available.

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[11] Source: State Board of Equalization.

RECOMMENDATION 4

PLANNING, TO BE EFFECTIVE, SHOULD BE BROAD IN SCOPE, FORMAL, AND CONTINUOUS. A PERMANENT COMMITTEE, BROADLY REPRESENTATIVE OF REHABILITATION INTERESTS, SHOULD BE APPOINTED FOR THE PURPOSE OF PROVIDING ADVICE, COUNSEL AND SUPPORT TO THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES. THE COMMITTEE WOULD ALSO HAVE RESPONSIBILITY FOR REHABILITATION PLANNING ACTIVITIES AND FOR THE PROVISION OF INFORMATIONAL SERVICES THROUGH THE UTILIZATION OF A PROFESSIONAL PLANNING COORDINATOR.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	LEGISLATURE

STATEMENT OF THE PROBLEM:

The scope of services and agencies who have involvement in rehabilitation is extremely broad.[13] The state rehabilitation agencies have a legal responsibility for rehabilitation of individuals and, consequently, must have a close and vital working relationship with not only the social service agencies listed but other segments of society. Planning also must, of necessity, be broad enough to allow consideration of the program developments and planning in related fields. Programs to be effective must be constantly evaluated if they are to keep pace with the factors of change in any society. Progress in technical knowledge and methods in related fields such as medicine, education, and psychology precipitate changes which affect the disabled. The changes which occur in the community itself in new technological advances which create new jobs and eliminate old ones; the shifting emphasis in welfare programs and Social Security; the changes in population characteristics, the economy, and in social values, these are but some of the forces that bear upon rehabilitation programs. Agencies must keep pace if their programs are not to stagnate and if the social demands of people are to be met.

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[12] Kraenzel, C. F., and Macdonald, F. H., The Social Cost of Space as a Criterion in the Distribution of Federal Grants.

[13] Refer to Chapter I, p. 10.

Planning can be as effective a tool in the social service field as it has proven to be in industry.

Federal grants available to Montana for programs of the Department of Health, Education, and Welfare totaled $23,809,185.00 for the fiscal year 1967. Almost 1.5 million of this amount was for support of Vocational Rehabilitation.[14]

The increasing population with its attendant complexity of individual problems assures that these expenditures will increase in the future. The judicious use of available funds to alleviate human problems and to return the disabled to productivity implies coordination of programs and development of services in accord with an overall plan. The development of programs in the past has occurred without consideration of allied programs and with little, if any, regard for coordination. The result has been duplication, wasted resources, and fragmented rather than comprehensive services.

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[14] U. S. Department of Health, Education, and Welfare, 1967 Annual Report.

When individual rehabilitative services, be they preventative, diagnostic, therapeutic, or vocational are uncoordinated and disorganized, manpower, time, effort, and skills cannot be fully utilized.

COMMENTS:

The conduct of broad rehabilitation planning in Montana by a permanent committee or commission with official status in state government would insure that coordinated planning in the rehabilitation field would reflect the interests of the many groups concerned with the disabled, and would also serve as overall coordinating function between the DVR, DBS, and other public and private agencies. As the two agencies also have legal authority in rehabilitation in Montana, they could benefit from the advice and counsel of a representative group.

A professional staff would be the functional component of the committee and would, under their direction, carry out not only planning activities but informational services which are essential components of rehabilitation.

The membership of this officially constituted group should be drawn from the disabled and the public and private groups who have demonstrated active interest in rehabilitation planning.

Funds could be made available through the two agencies which will be required to conduct planning activities as part of their regular program according to proposed amendments of the Vocational Rehabilitation Act of 1968.

Roren, remarking on the need for planning for health facilities, states principles that have equal application to rehabilitation planning:

1. ..., that facilities and services be established solely in accord with proven unmet needs;

2. that each facility or program should be developed in terms of a specific geographic area which may be shared with others;

3. that care should be comprehensive and continuous and may often involve joint action by service institutions;

4. that each program should provide sufficient volume of service to achieve quality and economy and that the public be kept fully informed about all existing or projected service and facilities.

The ultimate decision concerning the development or expansion of new facilities and services is properly the responsibility of the general public whose members will pay for these developments. In application of these principles he further states that a full time professional staff is needed and that sponsorship and support by public representatives are required.[15]

RECOMMENDATION 5

THERE IS A NEED FOR A FORMAL, ON-GOING PROGRAM OF INFORMATION AND EDUCATION BY THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES. THIS PROGRAM WOULD SERVE TO BETTER INFORM THE DISABLED, THE PROFESSIONALS IN RELATED FIELDS, AND THE PUBLIC OF REHABILITATION SERVICES. IT WOULD CREATE AN AWARENESS OF THE PROBLEMS OF THE DISABLED AND ASSIST IN DEVELOPING AN ATMOSPHERE OF ACCEPTANCE OF THE DISABLED IN THEIR COMMUNITIES. THIS ACTIVITY COULD BE A FUNCTION OF THE COMMITTEE REFERRED TO IN RECOMMENDATION 4.

SCHEDULE FOR IMPLEMENTATION: IMMEDIATE

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[15] Roren, R. C., "Areawide Planning is Here to Stay," Modern Hospital, August, 1964.

INITIATOR: DIVISION OF VOCATIONAL REHABILITATION

DIVISION OF BLIND SERVICES

LEGISLATURE

STATEMENT OF THE PROBLEM:

The provision of information is a necessary part of any agency program that provides services to people. If those people whom the agency is to serve are not fully aware of the resources and programs available to them, then obviously one of the most basic purposes of services to people is being thwarted. The information is necessary not only for those who will consume the services but for those providing services. The tremendous advancements in treatment methods, new services, and the increased resources available nationwide are also becoming more accessible to the disabled of Montana. Those persons in the helping professions must keep abreast of these developments if they are to make appropriate individual referrals to other agencies. As society becomes more complex, so will the problem of communication in regard to the resources that are available to help people. It is also incongruous that while Montana lacks many of the services that are essential to total rehabilitation of the disabled, long established programs of demonstrated excellence often are not fully utilized. That additional problems exist is well-defined in the following statement: "A common roadblock in all community work related to health and welfare, including that of rehabilitation, lies in the widespread ignorance on the part of the general public as to what health and social services are, where they are to be found, and how they can be used to raise the level of living

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for the entire citizenry. Constant interpretation and demonstration must be carried on through education, usually of the informal variety. Planned attacks on negative attitudes toward the disabled can include such informal devices as come-and-see tours, through which students, or adults who are influential in their particular spheres such as businessmen, company officials, plant foremen, personnel directors, civic club members, are taken on tours of sheltered workshops, rehabilitaion centers, or factories employing handicapped workers, where they can actually see the processes and the results of rehabilitation. Education is involved in curriculum planning which can include teaching of such subjects as social studies and civics, a study of the interdependence of people and the values to our democracy of providing adequate health, welfare, and rehabilitation services for all people."[16]

The assumption of responsibility for the health and welfare of the handicapped in our society has a legal as well as a moral basis. That this same responsibility has been assumed in the economic, emotional, and social areas of society is not reflected in the empirical evidence nor in that evidence presented by many studies which have been conducted. A summary of a series of studies by Roger Barker delineates the attitudes which must be overcome if the handicapped person is to be accepted in society. "Public verbalized attitudes toward disabled persons are, on the average, mildly favorable; an appreciable minority openly expressed negative attitudes. Indirect evidence suggests that deeper unverbalized attitudes are more frequently hostile - the evidence is rather clear that the attitudes of parents towards their disabled children tend to be extreme more often than towards normal children."[17] Only recently has there been a tendency on the part of public social agencies to accept, as a function of their program, the dissemination of information and the provision of educational materials to the general public and to the professional persons with whom they deal. The private agencies have long utilized public information programs, and it is largely through their work that the current level of acceptance of the disabled by the general public has been achieved. Those governmental agencies who do not deal with people per se, such as those in Fish and Game work or in highway construction, all effectively utilize public information and educational programs as a means of accomplishing their mission in the most expeditious manner.

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[16] Vocational Rehabilitation Administration, *Rehabilitation Agency and Community Work - A Source Book for Professional Training*, U. S. Department of Health, Education, and Welfare, Chapter II, p. 41, 1966.

COMMENTS:

That there are significant problems in the area reflected in this recommendation was recognized by seven of the districts, by the Citizens Advisory Committee, and the administrators of related agencies. A large body of professionals also have expressed a need for information on related rehabilitation programs and services, and this is indicated in the results of the Project surveys and by the comments of the respondents. The surveys conducted among the nurses and other professionals in Montana indicated the following results: 112 of 493 nurses surveyed indicated that they did not

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[17] Barker, R. G., Wright, B. A., Gonich, M. R., Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability, New York Social Service Research Council, 1966.

refer to the rehabilitation agencies because they were not familiar with them. Of these respondents, 246 indicated they felt that disabled people did not receive needed services because they did not have knowledge or information regarding them. The nurses indicated a considerable interest in learning more about the Division of Vocational Rehabilitation (170 nurses), and about the Division of Blind Services (101 nurses). A surprisingly large number felt the need for information on services in the medical and related fields; physical therapy (95); occupational therapy (132); recreational therapy (113); speech therapy (83); audiology (65); psychiatric social work (153); prosthetics (100). A lesser number of other professionals indicated that they did not refer the disabled to Vocational Rehabilitation and the Division of Blind Services because they did not know about the agencies (25 of 378 respondents); however, 206 of the total number of the respondents to the professional survey felt disabled persons were not receiving services because of lack of information on the part of the client. This group of 378 persons indicated that they wished additional information as follows: Division of Vocational Rehabilitation (139); Division of Blind Services (52); physical therapy (97); occupational therapy (103); recreational therapy (69); speech therapy (73); audiology (44); psychiatric social work (108); prosthetics (51). The responses of a segment of the target group for any information-educational program indicates their receptivity to such a program and that it would fulfill an actual need which would eventually result in better services to the disabled individual in Montana.

The importance of medical participation in rehabilitation is stressed by the report of the Committee on Rehabilitation of the American Medical Association; however, a survey showed that physicians possess relatively little knowledge about the state rehabilitation agencies. As physicians see the injured and the ill early, their knowledge of the agencies and their program is significant in determining whether or not early referrals are to be made.[18] Informational programs are therefore related to case finding and referral and the basic problem affects all disability groups. . .

In a report delivered at a special workshop on problems of the deaf, Vescovi listed the following components of a good case finding system as proposed by Ogles in 1962:[19] 1. Public education and information acquainting the public with the objectives and services of the agency; 2. Reaching the disabled through any media available to the agency and similarly acquainting them with such objectives and services; 3. Interpreting the same objectives and services to community resources which normally serve disabled persons, among others in their service program. Some continuous procedure must be involved because of agency personnel turnover; 4. Constantly promoting the development and maintenance of specific channels for helping the disabled to reach the agency.

Recognition of the need for informational programs is reoccuring in the literature. For example, the Research Conference on Rehabilitation in Cardiac Disease indicated that the education and cooperation of the school nurse and physical education instructor become vitally important in dealing with children who have cardiac restrictions.[20] They emphasize that while this can be achieved by letter from the physician to the individual patient, that a more suitable approach is through lectures, publications, and instruction which could be disseminated via the Department of Education.

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[18] American Medical Association, Committee on Rehabilitation, "The State-Federal Program of Vocational Rehabilitation," Journal of the American Medical Association, 171:8:1107-1109, October 24, 1959.

[19] Vescovi, G. M., "Case Finding, Referral, and Preliminary Survey," The Vocational Rehabilitation of Deaf People - A Report of a Workshop on Rehabilitation for the Deaf, pp. 5-8, U. S. Department of Health, Education, and Welfare.

[20] Zaver, A., "Rehabilitation Problems in Pediatric and Adolescent Cardiac Patients," Rehabilitation in Cardiac Disease, p. 151, Research Conference, Tufts University School of Medicine, November, 1967.

RECOMMENDATION 6

A COMPREHENSIVE PROGRAM IS NEEDED TO ENCOURAGE THE EMPLOYMENT OF DISABLED WORKERS IN MONTANA'S BUSINESS AND INDUSTRY BY ENLISTING THE SUPPORT OF EMPLOYERS, LABOR ORGANIZATIONS, SERVICE ORGANIZATIONS, THE CHAMBER OF COMMERCE, AND OTHER INTERESTED GROUPS.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	DIVISION OF VOCATIONAL REHABILITATION DIVISION OF BLIND SERVICES EMPLOYMENT SERVICE PERMANENT ADVISORY COMMITTEE

STATEMENT OF THE PROBLEM:

Placement of the handicapped worker in Montana is difficult, principally because of lack of knowledge on the part of employers and lack of a broad field of employment opportunities due to the few industries present in the state.

Resistance to hiring the handicapped stems from many preconceived ideas concerning their ability to perform, the hazards involved to all concerned, and the reluctance of other workers to accept the disabled. When the handicapped employee is hired, too often it is on the basis of pity and conscience rather than expectation that he will perform in a manner which will make him an asset to the enterprise. When the handicapped are hired in periods of relatively high employment, there is a tendency to let them go early in any reduction of activity. In many cases, the worker's actual performance is not closely evaluated, and he is treated, after being employed, according to preconceived ideas, and sometimes discharged without sufficient reason. Often the handicapped are paid a much lower wage than other workers for comparable duties. A great deal of educational effort is required to overcome the attitudes of resistance of persons connected with employment. Often the only effort in securing work for the disabled is on the part of a placement officer working with the employer. In order to change many of the attitudes discriminatory to the handicapped, a much broader approach to the problem is indicated.

While Montana has a dearth of light industry which might provide suitable employment to the handicapped, the service industries are on the increase and should offer many opportunities to the well-trained and capable worker.

Concerted effort of all groups interested in the disabled is necessary if employment of the handicapped is to be an accepted practice throughout the state.

COMMENTS:

This recommendation originated with the statewide Citizens Advisory Committee and District 7. The problem has been recognized in Montana, and a Governor's Committee on Employment of the Handicapped makes some effort periodically to encourage consideration of the disabled for employment. Potentially, the committee could be a very important factor if it were composed of broad representation of those vitally interested in the disabled, and if it conducted an active and continuous program throughout the year.

Many studies have been made which show the handicapped worker to be equal to, or in some respects superior to, the non-disabled.[21] Where hiring is done on a realistic basis of the worker's ability to perform in a particular job and where employers make minor physical arrangements, results are usually satisfactory. Employers who have had experience with disabled workers are most likely to hire more of them. It appears that workers with orthopedic disabilities are more readily hired than those having epilepsy, heart conditions, mental retardation, and those in the upper age brackets. It is in these latter categories particularly that much work is needed in overcoming employer resistance.

An article in the Rehabilitation Record states that more than one million epileptics in the United States are potentially capable of being taxpayers if given the chance. Although studies have shown that the controlled epileptic is more careful than the average worker, has less accidents on the job, and is absent from work less frequently, employment agencies report they are seldom successful in placing more than 2% of such persons.[22]

In a speech at the Oxford International Seminar, William Evans said that a major obstacle to vocational rehabilitation is the resistance of employers to employees who have had heart attacks. While the patient, medically certified as fit for a given occupation, can compete favorably with healthy workers, employers still view him as a risk.[23]

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[21] University of Minnesota, The Measurement of Employment Satisfactoriness, Minnesota Studies of Vocational Rehabilitation, No. 14, 1963.

[22] Fabing, H. A., "Legal Discrimination Affecting Employment of the Epileptic," Rehabilitation Record, 1:5:19-22, September-October, 1960.

Reasons given for not hiring the mentally retarded include the belief that their physical appearance bothers most people and that they have many emotional problems.[24]

Problems specific to the older disabled group are employer resistance to hiring older people, problems of insufficient education or out-of-date skills, and reduction of flexibility and mobility due to the aging process. To balance other problems, older workers often have the assets of superior judgment based on experience, dependability, loyalty, steadiness, and more mature attitudes toward work. Thirty percent of clients rehabilitated into competitive employment by the New York State Rehabilitation program in 1962 were 45 or over.[25]

Industrial accident legislation must also be changed if acceptance of the disabled is to occur.

A drawback to hiring the ex-mental patient or other handicapped individuals is the lack of a second injury law in some states. Such a law frees the employer of responsibility for physical or mental disability which develops in relation to previous disability, but leaves him responsible for any new condition which occurs while the handicapped person is in his employment. Such a law encourages employers to hire many handicapped individuals, such as an employee who has had a heart attack or one who has been mentally ill.[26]

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[23] Evans, W., "Employment and Rehabilitation of Patients With Heart Disease," Rehabilitation, Journal of the British Council for Rehabilitation of the Disabled, 54:7-15, July-September, 1965.

[24] Phelps, W. R., "Attitudes Related to the Employment of the Mentally Retarded," Occupational Information for the Mentally Retarded - Selected Readings, pp. 615-630, 1967.

[25] Warren, S. L., "Vocational Rehabilitation of the Older Disabled Person," Rehabilitation of the Older Disabled Worker - The Academician's Responsibility; Report of the Proceedings of a Conference on the... November 12-14, 1965, pp. 13-15. U. S. Vocational Rehabilitation Administration, (Vocational Administration grant #63-114).

Montana's second injury law is concerned only with loss of body members.

The safety record of the handicapped is as good or better than that of non-handicapped workers according to numerous studies. The subjects of these studies range from employees of small firms to the federal government.[27]

Yuker, Campbell and Block discuss implications of research findings regarding the value of pre-employment medical examinations. Examinations are used as a selection device to: (1) Eliminate potential employees who will not be productive because of excessive absence due to illness or physical disability; (2) Screen out those whose physical conditions make them likely to be accident prone; and (3) Determine whether the candidate possesses physical characteristics necessary to perform the job. The experience of Abilities Incorporated, a manufacturing company, refutes the validity of such examinations for these purposes in manufacturing. This company has no pre-employment physical and, in fact, employs only those who are physically disabled; i.e., those who probably could not pass an average pre-employment physical. Abilities Incorporated employees have better records than industry as a whole in both absenteeism and in safety. The employee absenteeism rate is 1.2 days per 100 work days vs. 3.1 per 100 in industry, over a seven-year period with a current work force of 400. Four compensable accidents occurred in that time. Insurance premiums based on experience are less than 50% those of comparable companies.[28] Similar experiences are reported by Cowing on the employment experience of Repcal Brass which has 30% handicapped in its labor force.[29]

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[26] Industrial Panel, Frost, E. S., Moderator, Industry in the Mental Hospital; a Workshop, April 22-23, 1964, Hotel New Yorker, New York City; Proceedings.

[27] McCahill, W. P., "Incidents of Accidents Among Handicapped Workers," Disability Prevention, Rehabilitation; Proceedings of the Ninth World Congress of the International Society for Rehabilitation of the Disabled, Copenhagen, Denmark, June 23-29, 1965, pp. 53-56, International Society for Rehabilitation of the Disabled, 1965.

RECOMMENDATION 7

IT IS RECOMMENDED THAT CONSIDERATION BE GIVEN TO THE EXTENSION OF REHABILITATION SERVICES AND PROGRAMS TO THOSE INDIVIDUALS WHO ARE UNABLE TO FUNCTION SOCIALLY, ECONOMICALLY, OR EDUCATIONALLY IN SOCIETY, IN THE SAME MANNER IN WHICH SERVICES HAVE BEEN EXTENDED TO THE PHYSICALLY HANDICAPPED, EMOTIONALLY DISTURBED, AND MENTALLY RETARDED INDIVIDUAL. SUCH PROGRAM MODIFICATION SHOULD BE ENCOURAGED AS RAPIDLY AS RESOURCES PERMIT.

SCHEDULE FOR IMPLEMENTATION: INTERMEDIATE

INITIATOR: DIVISION OF VOCATIONAL REHABILITATION

STATEMENT OF THE PROBLEM:

The federal laws and regulations that affect the administration of the Vocational Rehabilitation program have tended to broaden eligibility requirements to include those persons who are vocationally handicapped due to other than physical or mental conditions. The 1966 Revision of Regulations in reference to implementation of the 1965 Amendments to the Vocational Rehabilitation Act (PL 89-333) states in Section 401.1 (o): "'Physical or mental disability' means a physical or mental condition which materially limits, contributes to limiting or, if not corrected, will probably result in limiting an individual's activities or functioning. It includes behavioral disorders characterized by deviant social behavior or impaired ability to carry out normal relationships with family and community which may result from vocational, educational, cultural, social, environmental or other factors."[30]

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[28] Yuker, H. E., Campbell, W. J., Block, J. R., "Selection and Placement of the Handicapped Worker," Industrial Medicine and Surgery, 29:9-419-421, September, 1960.

[29] Cowing, F., "What Personnel Has Learned From the Handicapped at Repcal Brass Co.," Reports on Employment of the Handicapped; Personnel and Industrial Relations, Two Doctors, the Safety Engineer, pp. 9-13, Government Printing Office, 1958.

Despite the recognition that rehabilitation programs can be applied with effect to alcoholics, delinquents, habitual criminals, and others who can be classified according to the above definition, the Montana program has not been able to extend services to other than those with clearly defined physical or mental conditions. To extend services to all disabled is presently beyond the resources of the state agency.

A program of services to a select number of individuals within this broadened category was initiated by the State Department of Institutions, utilizing federal funds available through the Division of Vocational Rehabilitation. The Swan River Youth Forest Camp has received substantial equipment and programs to enable rehabilitation services to be provided delinquent youth. Legislative appropriations to the state agency have not been adequate to enable full implementation of Vocational Rehabilitation services to all such persons in Montana.

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[30] Vocational Rehabilitation Administration, Federal Register, Revision of Regulations, 31:9:2:499, Department of Health, Education, and Welfare, January 14, 1966.

The number of individuals in the community who are eligible and would utilize services under this broadened definition is unknown; however, many of those in the custodial institutions could benefit from the services of Vocational Rehabilitation.

The experiences of other states' rehabilitation agencies have demonstrated the efficacy of applying rehabilitation techniques to the problems of alcoholics, the aged, the delinquent, and the public offender.

COMMENTS:

The failure of our society in dealing with the individual having behavior problems emanating from vocational, educational, social, and similar factors is reflected in the increase in school dropouts, deviant social behavior, alcoholism, and in the increasing costs of public assistance. This feeling was expressed directly in the recommendation of six of the Districts, and by those agency administrators who deal with the end result of individual and societal deficiencies.

Wessen clearly makes the point: "In a sense, rehabilitation may be said to have been made necessary because of the failures of prior institutions, for it is the aim of the field to overcome the handicaps of those whose physical impairments, psychological maladjustments, or vocational inadequacies make it impossible for them to lead independent, productive lives. It has been an assumption of our culture that the primary socializing and treatment institutions - the family, the school, medical practice - should so function as to create and maintain responsible adults."[31]

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[31] Wessen, A. F., "The Apparatus of Rehabilitation - An Organizational Analysis," Sociology and Rehabilitation, p. 153.

Florida's Alcoholic Rehabilitation program found that alcoholics required assistance in the area of employment to a degree equal with their need to find ways to control their drinking. Despite the complex problems faced by alcoholics, one-third of all individuals referred to the program were satisfactorily employed. The remainder were not accepted for service as they did not meet eligibility requirements in effect at that time. Of the total number accepted for service, 60% were rehabilitated. Inability to tolerate the stresses of the normal work setting, rather than employment per se, was found to present a major problem in the vocational adjustment of alcoholics.[32]

Weil and Price concluded that of those persons in the Baltimore city jail for drunkenness, vagrancy, and disorderly conduct, most required a minimal amount of medical care but a maximum of social, emotional, and vocational rehabilitation and reintegration into the community.[33]

South Carolina has a program of rehabilitation for public offenders, and by applying the services and techniques long used with other handicapped persons, 100 offenders were returned to jobs in the first eighteen months of the program. Medical, psychological, and vocational services are initiated as soon as the prison sentence is begun, as part of a coordinated treatment and rehabilitation program.[34] A Wyoming DVR pilot project provides the full scope of services to inmates meeting eligibility requirements, and a special pre-release orientation component is part of the program.[35]

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[32] Williams, J. H., Florida Project on Followup Adjustment of Alcoholic Referrals for Vocational Rehabilitation, p. 59, Vocational Rehabilitation Administration Research Grant 1472-P, Department of Health, Education, and Welfare.

[33] Weil, T. P., Price, C. P., "Alcoholism in a Metropolis," Crime and Delinquency, 9:60-70, 1963.

[34] Rigdon, D., "South Carolina's Public Offender Program," Rehabilitation Record, 8:4:26-29, July-August, 1967.

The low income family is the focus of a special project of the Georgia DVR, and over 4,000 families each year receive evaluation, assessment of work potential, and necessary medical and psycho-social services. Suitable employment is the major goal of this program which serves individuals from 16 to 65 years of age.[36]

RECOMMENDATION 8

THE IMMEDIATE DEVELOPMENT OF SPECIAL CLINICS AND CAMPS SHOULD BE UNDERTAKEN TO SERVE THE DISABLED CHILD IN THE PRE-TEENAGE GROUP. CHILDREN AFFLICTED WITH CONDITIONS SUCH AS DIABETES, EPILEPSY, MENTAL RETARDATION, BLINDNESS, OR DEAFNESS REQUIRE SPECIAL ASSISTANCE IN PERSONAL AND SOCIAL ADJUSTMENT TO THE DISABILITY, IN ESTABLISHING AND MAINTAINING AN EFFECTIVE SELF-CARE PROGRAM, AND IN FOLLOWING A PROPER MEDICAL REGIMEN.

SCHEDULE FOR IMPLEMENTATION: IMMEDIATE

INITIATOR: PUBLIC HEALTH
PRIVATE GROUPS

STATEMENT OF THE PROBLEM:

The disabled child is often subject to either over-protection or isolation. He must overcome not only the primary limitations imposed by the disabling condition, but often the greater obstacles of negative attitudes of his family and his peers. The presence of such attitudes at the critical stage of the child's development can adversely affect subsequent personal, social, and vocational adjustment. The availability of an effective self-care program at an early age could prevent the development of secondary disabling conditions.

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[35] Stugart, D. B., "Helping the Public Offender," Journal of Rehabilitation, 33:4;13-14, July-August, 1967.

[36] Jarrell, A. P., "New Start for Atlanta's Poor," Rehabilitation Record, 7:3;27-36, May-June, 1966.

Special clinics have proven effective in the identification and clarification of problems in initiating treatment programs, in providing parental counseling, and in coordinating future planning for the child.

Camps provide an opportunity for participation in recreational, social, and developmental activities under competent professional supervision. Through structured group activities at a level commensurate with functional limitations, a more positive and realistic self-concept can be developed.

The capacity of a disabled person to function is often inhibited more by attitudes than by the functional limitations of the condition. A poor self-concept will likely result in a poor social adjustment. Positive attitudes, together with medical supervision at an early age, can minimize or eliminate the need for more costly rehabilitative services later in life.

COMMENTS:

The programs operating under the Crippled Children's Service of the Montana State Department of Health have demonstrated the value of clinics for disabled children. These programs, which were originally developed to serve orthopedically handicapped children, now provide diagnosis and treatment to those with orthopedic or neurological conditions, congenital heart disease, neoplasms, and rheumatic fever. In addition, that agency provides services to children with cleft palates. These programs are primarily treatment oriented, but offer the potential for greater expansion to include more disability categories and additional adjustive services, if resources were available. Children suffering from cardiac conditions, diabetes, epilepsy, blindness, deafness, and mental retardation would benefit from similar programs.

Voluntary health agencies have long sponsored special camps for certain disabilities. The American Diabetes Association has established standards for camps for children and lists 39 camps in the United States.[37]

These camps provide experiences emphasizing self-reliance, basic habits for maintaining good health, regulation of diabetes, and a balanced social adjustment in addition to recreational activities. Diabetes can be controlled, but to do so requires a planned diet, exercise and, when necessary, insulin.

The National Epilepsy League states: "The child with epilepsy wants and should be treated in a completely normal way with emphasis on wholesome living. A healthy, happy, and active life reduces the likelihood of seizures."[38]

Similar programs are of paramount importance to other disabled children. Private agencies and service clubs should be encouraged to sponsor camps, under competent professional leadership, to meet the unique needs of children with disabling conditions.

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[37] American Diabetes Association, Inc., Facts About Diabetes, p. 22, 1966.

[38] National Epilepsy League, "Advice for the Parents of an Epileptic Child," Horizon, p. 3.

The ready availability of suitable camp sites in Montana should facilitate the development of these activities for the disabled child. The Montana Association of the Blind and the Division of Blind Services sponsor a summer school for the adult blind on the campus of Montana State University, and it incorporates some of the functions of camps. The Easter Seal Society has initiated camps in Montana for orthopedically handicapped children.

RECOMMENDATION 9

THERE IS A NEED FOR CONTINUED AND STRENGTHENED COOPERATION AND COORDINATION AMONG AGENCIES TO PREVENT COSTLY DUPLICATION AND TO PROVIDE THE BEST POSSIBLE SERVICES AT A REASONABLE COST. IT IS THEREFORE RECOMMENDED THAT THOSE GOVERNMENTAL AGENCIES WHICH PROVIDE SERVICES TO DISABLED PEOPLE TAKE THE NECESSARY STEPS TO INSURE THAT THIS COOPERATION EXISTS.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	PRIVATE AGENCIES PUBLIC AGENCIES LEGISLATURE

STATEMENT OF THE PROBLEM:

The achievement of complete cooperation may be unrealistic and impractical for many reasons; however, determined efforts must be made by all agencies and professionals at all levels if the focus of all programs - the handicapped individual - is to receive maximum benefit. The problem of coordination and cooperation is a universal one and has many ramifications. Ropchan listed five conditions which are conducive to developing cooperative relationships: (1) A spirit of cooperation among agencies, fostered by each agency having clearly defined goals and convictions regarding its individual program; voluntary agencies can provide practical assistance to public agencies, in, e.g., financing demonstrations within the public agency and providing opportunities for the public agency to interpret its programs and needs; (2) Willingness to subordinate interest of own agency to larger common interest, instead of jealously guarding prerogatives; (3) Willingness to share credit for results of cooperative action; (4) A strong central planning organization with competent staff; and (5) Identification of the agencies with the central planning body; member agencies should clear their own programs with the organization, assume responsibility for participating in the planning activities, give serious consideration to recommendations that come out of the planning process, and help finance the operations.[39]

Benney[40] relates experiences at the Altro Health and Rehabilitation Services as follows: Experience at the Altro Health and Rehabilitation Services has shown that integration in rehabilitation is important at four levels: (1) interagency, (2) interprofessional and intra-agency, (3) family, and (4) individual. Cooperation between agencies is implicit in any integrated scheme of services from initial case finding through treatment and follow-up. Stages in interagency cooperation have been described in one source as: (1) the competitive or chaotic stage; (2) awkward attempts at cooperation where one agency makes a plan and expects another to carry it out; and (3) routine divisions of cases on the basis of territory, nature of need, etc. described as "joint traffic agreements" among agencies. A fourth stage, representing truly integrated working relations, is based on responsibility and deepened understanding, rather than contractual agreements. Altro Workshops Incorporated of New York City and the New York City Welfare Department have established a cooperative relationship whereby Altro clients coming from all districts of New York City are centralized in one special service office of the Welfare Department, with two investigators interviewing the patients at the workshop as necessary. This cooperative effort has insured that patients quickly receive necessary assistance; further, it has decreased absenteeism due to welfare office visits, and promoted the rate of rehabilitation.

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[39] Ropchan, A., "The Need of Integrating the Community Rehabilitation Agency and Disciplines," Journal of Rehabilitation, 26:3:4-7, 45-47, May-June, 1960.

[40] Benney, C., "Integrative Aspects of Rehabilitation," Journal of Rehabilitation, 25:3:13-15, 24-25, May-June, 1959.

COMMENTS:

All Districts recognized that cooperation and coordination of service activities and programs are not adequate. The problems of communication which result from conflicting philosophies, standards, procedures, and terminology are not readily overcome. Common objectives are not sufficient to eliminate the problem. What is more necessary is the recognition that cooperation will enable each to better achieve its goals and objectives. Informal rather than formal meetings have proven effective in facilitating communications.

RECOMMENDATION 10

IN ORDER TO PROMOTE INTER-AGENCY COOPERATION AND COORDINATION AND TO IMPROVE THE DELIVERY OF SERVICES TO THOSE IN NEED, IT IS RECOMMENDED THAT AS OFFICE SPACE IS LEASED OR CONSTRUCTED IN MONTANA, PLANS BE MADE TO LOCATE ALL SOCIAL AND HEALTH AGENCIES WITHIN THE SAME BUILDING. THIS CLOSE PROXIMITY OF RELATED AGENCIES WOULD ALSO FACILITATE THE POOLING OF SPECIALIZED PERSONNEL WHO COULD FUNCTION FOR MORE THAN ONE AGENCY.

SCHEDULE FOR IMPLEMENTATION: LONG RANGE

INITIATOR: LEGISLATURE

STATEMENT OF THE PROBLEM:

Inter-agency coordination is, under the most ideal of conditions, a difficult process. As many deterrents to a smooth communication process as possible should be eliminated. The ready accessibility of operational staff of the related agencies to each other is perhaps even more important than interaction at the administrative or policy level. The delivery of services to the handicapped person by related agencies must be in harmony with overall objectives, must be timely, and should be as comprehensive as the needs demand and the resources of the several involved agencies permit. A concentration of agencies at the operational level has been proven to have many advantages which are particularly apparent when related to rehabilitation oriented services and agencies. The process of rehabilitation, by its very nature, involves the coordination of many and varied services in behalf of the individual.[41] In addition to expediting delivery of services, other benefits are realized, opportunities for strengthening cooperation are enhanced, time and energy are conserved, and sharing of critical staff members becomes feasible.

COMMENTS:

The types and number of services utilized in rehabilitating, whether vocational or general in nature, is formidable, and at times, certainly confusing and frustrating to the individual seeking assistance.[42] While practical considerations preclude grouping some of the services used, many others can be placed together. More by accident than design, this centralizing by function has occured in other states, notably Oregon, which has built or leased state office buildings in the communities. Agencies which should be accessible to each other because of common cases and referral problems are in the fields of correction, employment, public health, mental health, welfare, rehabilitation, and social insurance. Such a concentration of services has been the key ingredient of successful total programming of services. Its worth has been demonstrated in medical clinics, in rehabilitation centers, and in mental hospitals. It has been most notably successful in Cleveland, Ohio in the Vocational Guidance and Rehabilitation Service. In Cleveland, which has a tradition of consolidation of social agencies, it was felt necessary to move the facilities of several private agencies under one roof. Each maintains its autonomy and integrity of its operation and Boards, but all benefit through the cooperation and coordination possible, and disabled persons receive far better services than would otherwise be possible.[43] The construction of the Missoula County Courthouse Annex has enabled a grouping of agencies never before possible. More positive interagency relationships have resulted in greater cross referral of clients and case coordination. The opposite situation exists in other Montana cities where agencies are scattered throughout the city, with consequent problems for mutual clients and wasted staff efforts in effecting coordination. Lack of public transportation in such a situation often discriminates against the individual most often needing the coordinated services of the agencies.

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[41] NOTE: Caseload Study indicates, of cases reviewed, 56.8% received funds from other agencies, 6.8% had a lack of resources that could have been provided by other agencies, and 4.8% were not helped because resources were not available through DVR.

[42] Refer to Chapter I, p. 10.

RECOMMENDATION 11

IT IS RECOMMENDED THAT THE UNIVERSITY SYSTEM TAKE THE INITIATIVE IN TRAINING PERSONNEL TO MEET THE STAFF REQUIREMENTS OF THE MENTAL HEALTH FACILITIES, ALLIED PROFESSIONAL AGENCIES, AND PROFESSIONS IN THE REHABILITATION FIELD.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	UNIVERSITY SYSTEM

STATEMENT OF THE PROBLEM:

The shortage of trained personnel in the health, social service, and rehabilitation professions is a problem of national magnitude; however, such shortages have an impact that is particularly felt in rural areas where the shortage often means not a lesser degree of service but no service at all. This is the case in several of Montana's counties where there are no physicians, speech therapists, physical therapists, public health nurses, and others who are vital to health and rehabilitation. Unfortunately, prospects for services by these people in most areas of the state seem dim unless new and innovative methods directed towards the training of these people and the utilization of the existing manpower are soon implemented. The Department of Labor estimates that total demands for those in the health field will continue to rise and estimates are that between 3,735,000 and 3,979,000 persons will be needed by 1975.[44]

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[43] Ginn, R. M., "Cleveland Initiates Unique Program for 'People Renewal,'" *Journal of Rehabilitation*, 32:1:41-42, January-February, 1966.

While certain professional careers can only be offered in Universities with medical school affiliations, others can be incorporated in non-medical academic settings. Training and programs initiated by the University system, in cooperation with public and private agencies, could be further expanded to include training at both the professional and sub-professional level.

Some progress in this direction is being made; however, the existing programs have not been developed to the extent they must be to meet demands for professionals in Montana.

According to the latest available information on the numbers of professional people in Montana who are connected with rehabilitative endeavors, there is one physical therapist to each 14,120 persons; there is one occupational therapist to each 41,529; there is one speech therapist to each

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[44] U. S. Department of Health, Education, and Welfare, Health Manpower Perspective 1967, p. 15.

16,045; there is a DVR or DBS counselor to each 33,619; there is one professional social worker to each 12,836; there is a physician to each 965; and there is one public health nurse to each 5,883.

COMMENTS:

All of the District committees were concerned with this problem, as shortages of personnel create immediate and devastating effects on services ranging from treatment of a medical nature through speech therapy, physical therapy, social work, special education, and nursing.

Acker in commenting on the problem of personnel stated, "Higher education, a multi-faceted, complex, and often controversial institution in our society, has many responsibilities. Two among them are particularly germane to a consideration of its role in the current manpower crisis in general and in rehabilitation in particular: these are its responsibility to prepare students for public service careers and to assist in the classification and solution of public problems. In the field of rehabilitation, therefore, higher education is challenged to provide the community with ever increasing numbers of adequately trained practitioners. It appears, unfortunately, less often challenged, by the community or from within its own confines, to examine critically the objectives of rehabilitation which, after all, should provide the basis upon which it determines how to best meet society's manpower needs."[45]

That academic training without consideration of the specific needs of those at the operational level is not adequate, is emphasized by Mott who points out that the fundamental problem with graduates of professional schools is a lack of adequate understanding of the organization into which they come to work and of the professional relationships within which they must perform effectively. They often have a limited concept of their place in the complex of health services and institutions and lack understanding of the functioning of the rehabilitation team.[46] A program reported on by Younie describes a program of Columbia University which introduced rehabilitation materials and philosophy into the curricula for special education teachers.[47]

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[45] Acker, M., "Higher Education and the Manpower Crisis in Rehabilitation," Rehabilitation Manpower in the West, p. 1, April, 1968.

RECOMMENDATION 12

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION PLACE INCREASED EMPHASIS ON THE ROLE OF THE TOTAL FAMILY IN THE REHABILITATION PROGRAM OF THE DISABLED PERSON THROUGH THE PROVISION OF FAMILY COUNSELING. CONSIDERATION OF THE TOTAL FAMILY, AS AN INFLUENTIAL FACTOR, WOULD OFTEN HELP TO INSURE A MORE SUCCESSFUL INDIVIDUAL REHABILITATION PLAN.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DIVISION OF VOCATIONAL REHABILITATION DIVISION OF BLIND SERVICES

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[46] Mott, B. J., "Some Relationships Between Rehabilitation Facilities and Universities," Selected Papers, Thirteenth and Fourteenth Annual Workshops, November 1964, November 1965, pp. 21, 22.

[47] Younie, W. J., Connor, F. P., Goldberg, I. I., "Teaching Teachers About Rehabilitation," Rehabilitation Record, 6:3:32-38, May-June, 1965.

STATEMENT OF THE PROBLEM:

The emphasis of all treatment, whether of a medical; psychological, or vocational nature, has traditionally been directed toward the problems evidenced and expressed by the disabled person, to the exclusion of many other vital considerations. The family and its effects on the ultimate course of the rehabilitation program has increasingly come under study. Despite the recognition that the family is often a substantial positive or negative influence, there is no formal mechanism through which the family of the disabled child or adult can receive counseling. The social work profession particularly has stressed the importance of including the family in any planning. The services of family counseling are, to a degree, available through the clergy, the mental health clinics, and the welfare agencies. With the exception of the mentally ill, however, there is no specific statewide service that extends family counseling services to other disability groups in Montana. To insure that such a program is available to a majority of disabled, consideration should be given to incorporating such a program in the vocational rehabilitation agencies.

COMMENTS:

The large service gap in the area of family counseling was particularly a concern of the Citizens Advisory Committee and two of the Districts. A review of rehabilitation literature confirms that many professionals in the helping professions identify this area as one which is vital in working with the disabled. It also appears to have received little in the way of programming to alleviate it. The total family is ultimately affected by disability of any member of the family, be they wage earner, wife and mother, or child. The consequences are felt economically, socially, psychologically, and particularly so in instances of sudden, substantial disabilities.

The Closed Caseload Study[48] indicated that in 13% of the cases, the lack of interest by the family was a significant deterrent to rehabilitation to the degree that the program had to be terminated. In addition, in 17.1% of the cases, the individual's attitudes, which can be presumed to be influenced by the family, stood as a deterrent. The evaluators also felt that on the basis of case file data, family counseling and social casework were needed services.

Gelfand in describing personal problems and family adjustment of the cardiac patient stated: "Apparently, when the patient relinquishes his role as the major provider in the family, the family unit itself changes. Marital discord and other family problems become more marked."[49] Garrett, in speaking of the employment of the cerebral palsied individual, flatly states that the most important single factor which predicts vocational success in vocational rehabilitation is family solidarity and family support.[50] The family and its relationship to the epileptic child was described thusly: "Directly influencing the epileptic is the family's tendency toward blamefinding, and as the child grows older he may blame virtually everyone for his condition. During the early days of life, a child learns where his parents are vulnerable, where he may have power over them, so in a family where the family attaches great importance to the seizure, this will influence the relationship within the family... . The family may worry, wonder, feel jealous, rejective and guilty."[51] Experiences at Pioneer Fellowship House, a halfway house for alcoholics, led to the employment of a family therapist who worked with the family, and particularly wives, in developing understanding, cooperation, and positive rehabilitation activities.[52]

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[48] Refer to Chapter VIII.

[49] Gelfand, D., "Factors Related to Unsuccessful Vocational Adjustment of Cardiac Patients," Rehabilitation in Cardiac Disease, p. 106, Research Conference, Tufts University School of Medicine, March 3-4, 1966.

[50] Garrett, J., "Total Life Planning for the Cerebral Palsied-New Concepts of Vocational Rehabilitation," Total Life Planning for the Cerebral Palsied; New Concepts of Vocational Rehabilitation; Proceedings of the Professional Training Institute, United Cerebral Palsy Association, June 3-6, 1964...Michigan State University, East Lansing: Kellogg Center for Continuing Education, Michigan State University, 1964.

Neser and Tillock in relating the role of the social worker to quadriplegic patients note that because of the severe physical limitation, it is difficult for the patient to accept reality regarding his disability and its permanence. The family too may find it difficult to accept and may reinforce the patient's efforts to deny reality.[53]

McFarland suggested the vocational rehabilitation counselor counsel with the family as well as the client to overcome family attitudes that deter rehabilitation, but recognized that the average vocational counselor has not been trained to deal with such specialized work or family counseling, and that the time demands on the counselor precludes counseling in depth. He suggested that a family counseling specialist be included on vocational rehabilitation staffs.[54]

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[51] Falther, A., "Family, Friends, and Frustrations," in Total Rehabilitation of Epileptics, p. 42., U. S. Department of Health, Education and Welfare.

[52] Adamek, R., "The Family Therapist as an Important Adjunct to a Halfway House Therapy Program," Report of 2nd Annual Conference Association of Halfway House Alcoholism Programs of North America, Inc., Seattle, Washington, October 22-25, 1967, pp. 63-64.

[53] Neser, W. B., Tillock, E. E., "Special Problems Encountered in the Rehabilitation of Quadriplegic Patients," Social Casework, 48:3:125-129, March, 1962.

[54] McFarland, D. C., "The Importance of Family Attitudes in Vocational Rehabilitation," New Outlook for the Blind, 51:10:443-445, December, 1957.

RECOMMENDATION 13

IT IS RECOMMENDED THAT WAGE SCHEDULES BE ESTABLISHED AT A LEVEL THAT WOULD INDUCE NEEDED PERSONNEL IN THE THERAPEUTIC AND SOCIAL SERVICE PROFESSIONS TO SEEK EMPLOYMENT IN MONTANA AND WOULD RETAIN EXISTING PERSONNEL. THIS IS ESSENTIAL IF THE EXISTING AND ANTICIPATED NEEDS OF THE DISABLED ARE TO BE ADEQUATELY MET.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	PUBLIC AND PRIVATE AGENCIES LEGISLATURE

STATEMENT OF THE PROBLEM:

The shortages of trained personnel in these fields have been well documented by others and by empirical evidence, as reflected in agency personnel turnover. It is recognized that manpower presents complex problems, and no one aspect alone assures that necessary personnel will be available to serve Montana's disabled. To attract new personnel and to retain those now employed, public and private agencies must consider salary schedules competitive with the urban centers where many of the training facilities are located and where other attractions exist. While many of the professionals in Montana are here because of other advantages, the competition with other states for them is on a predominantly economic basis. Three of Montana's counties have no resident physicians; 13 counties have no academically trained social workers. The total of academically trained (M.S.W.) social workers within the state is 55. These are not adequate to meet the special casework needs of the mentally ill, the retarded, the alcoholics, and other groups needing medical or psychiatric services. Of the state's 56 counties, 46 do not have a resident physical therapist, one of the most basic and necessary of the rehabilitation professionals.

Speech therapists are not available in sufficient numbers to meet the needs of children and adults adequately.

The migration of trained people into other more lucrative jobs seems exemplified in those fields traditionally staffed by men. Physical therapy is such a field.

COMMENTS:

The personnel study authorized by the Legislature and conducted by J. L. Jacobs & Co. will, if implemented, hopefully provide a basis of equitable treatment for those employed by the State of Montana in the therapies and other service professions.

"Competition from other agencies and low salaries were listed by an overwhelming majority (of agencies) as the factors which cause the most difficulty when trying to recruit rehabilitation counselors."[55]

The results of the Professional Survey[56] did not indicate that salary, in itself, is of paramount importance, as expressed by the preponderance of the employed group who responded. The survey does not, however, indicate the number of the non-respondents not working because of salary, and there is no way of ascertaining the role of low salary as a factor in not working.

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[55] Western Interstate Commission on Higher Education, "Rehabilitation Counselors for the West: Report of Regional Survey," Rehabilitation Manpower In the West, pp. 49-52, April, 1968.

[56] Refer to Chapter VIII.

RECOMMENDATION 14

IT IS RECOMMENDED THAT INCREASED FUNDS BE MADE AVAILABLE BY BOTH THE STATE AND FEDERAL GOVERNMENT FOR IN-SERVICE TRAINING PROGRAMS AND SERVICES, BOTH IN AND OUT-OF-STATE, AND THAT THE DIVISION OF VOCATIONAL REHABILITATION ADOPT A PROGRAM WHICH PROVIDES FINANCIAL ASSISTANCE AND ENCOURAGEMENT TO PROFESSIONAL STAFF WHO WISH TO UPGRADE THEIR JOB SKILLS AND PROFICIENCY.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DIVISION OF VOCATIONAL REHABILITATION DIVISION OF BLIND SERVICES

STATEMENT OF THE PROBLEM:

The academic training which the rehabilitation worker receives provides a basis of understanding and knowledge. It offers a starting point for professional development which is constantly being modified by the demands of the job, the new methods of treatment being developed, changes in societal patterns, and other influences. The backgrounds of those employed are often diverse and of varying degrees of experience. In order that overall program objectives can be realized, it seems imperative that methods be devised to assure that a continuing program of staff development and training be implemented. Professional isolation from new ideas and concepts is particularly acute in a sparsely populated area such as Montana, and this can be alleviated to a degree by both in-state and out-of-state professional training programs.

COMMENTS:

This recommendation was made by two of the District committees. The majority of professionals responding to the survey indicated that they are permitted to take time from employment to attend courses; however, 42% indicated that their employing agency did not have in-service training programs. These respondents recognize that the formal academic training they received prior to employment is not adequate in meeting the demands of employment and this is substantiated by the fact that 213 of the 378 respondents said they had gained considerable knowledge in school but had learned more on the job. An additional 44 indicated a minimal amount was learned in school, and 107 indicated most or all of their knowledge was gained in the classroom.

Specialized training is often necessary in employment. The unique problems of certain disability groups such as the blind, deaf, retarded, or mentally ill require a high level of training and sophistication if comprehensive care services are to be extended.

The Rehabilitation Services Administration (formerly Vocational Rehabilitation Administration) provides numerous in-service training opportunities in specialized areas to rehabilitation personnel. Some of these opportunities provide stipends; however, often the state or private agency is not able to allow staff members to participate because of shortages of personnel and cost related factors.

Funds available to the Division of Vocational Rehabilitation for staff training was $2,667.00 in fiscal year 1967, and $770.00 was available to the Division of Blind Services for the same period. These funds are obviously inadequate for the purpose.

The sponsorship of training institutes and seminars by the state rehabilitation agencies would allow those professionals in related fields to become more effective in the identification and referral of the disabled, in the application of new rehabilitation knowledge and techniques, and in becoming more aware of the unique problems presented by disability. That there is a need for such programs can be inferred from the results of the Professional Survey. An analysis of the responses indicates a rather significant number of professionals with less than three years of professional experience, apparently with a great deal of responsibility for case decisions, but having a minimal amount of supervision. The considerable number of persons indicating a need for more information on related profssions should also be considered in assessing the need for such in-service training programs.

Angers presents guidelines for the vocational counselor working with epileptics, and points out the obvious, but not so often followed tenet, that he first must have knowledge. He must know the facts on epilepsy, the medications utilized, and how to deal with seizures.[57] Similar knowledge is needed with other disabilites. DiMichael cites a proposal to meet the shortage of trained personnel which advocates the employment of persons with a Bachelor's Degree, with work-graduate training programs an integral part of the employment.[58]

In the present Division of Vocational Rehabilitation staff, three members hold Masters' Degrees - one each in rehabilitation counseling, counseling psychology, and music. Sixteen have Bachelor's Degrees, one in biological science, one in political science, six in sociology, two in journalism, two in business administration, three in education, and one in psychology.

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[57] Angers, W. P., "The Challenge of the Epileptic to the Vocational Counselor," The Vocational Guidance Quarterly, 12:3:175-178, Spring, 1964.

[58] DiMichael, S. G., "New Directions and Expectations in Rehabilitation Counseling," Journal of Rehabilitation, 33:1:38-39, January-February, 1967.

In the Division of Blind Services staff, four members have Masters' Degrees, two in rehabilitation counseling, one in educational counseling, and one in social welfare. Four have Bachelor's Degrees, three in education, and one in social work.

RECOMMENDATION 15

EFFORTS AIMED AT THE PREVENTION OF DISABILITY AND HANDICAPPING CONDITIONS THROUGH EDUCATION, EARLY DETECTION, AND REFERRAL ARE ESSENTIAL ASPECTS OF REHABILITATION, AND NECESSARY STEPS MUST BE TAKEN TO INITIATE SUCH PROGRAMS.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DEPARTMENT OF HEALTH DEPARTMENT OF PUBLIC WELFARE DEPARTMENT OF PUBLIC INSTRUCTION MENTAL HEALTH AUTHORITY

STATEMENT OF THE PROBLEM:

Permanent disability can often be prevented or minimized if programs of education, early diagnosis, and prompt referral are available to all individuals in the state. The necessity for treatment and rehabilitation programs, often of a long, costly nature, can be eliminated in certain instances if prompt attention is given to the cause. The programs that must be developed should be specific in direction, but broad in application, if they are to be effective. Accident prevention through education, study of hazardous conditions, and modification of environment has contributed to significant accident reductions in industry and in society generally.

Existing programs must be strengthened and expanded. Programs should be developed with an emphasis on education and prenatal care for expectant mothers, accident prevention in the home, at school, in industry, and during recreational activities. Early detection and referral of the disabled for treatment is vital when a condition occurs despite the best efforts of a preventative program. Existing agencies offer programs which, while excellent in content, are often limited in scope, with consequent neglect of significant areas which contribute to the problem of disability.

COMMENTS:

Comprehensive rehabilitation programs must include programs of prevention. Chronic diseases account for 88% of all cases which could benefit from rehabilitation; congenital conditions for 2%; and the remaining 10% are due to accidents and injuries on the job, in the home, or on the highway.[59] Voluntary health agencies have traditionally offered programs to increase public and professional awareness. A public agency noted for similar programs of education, detection, and treatment is the Montana Department of Health which has an extensive program in certain areas, specifically communicable diseases, maternal health care, crippled children's services, cleft palate, and hearing conservation. Comprehensive services for the mentally retarded received needed impetus through a Mental Retardation Planning and Implementation Project. Substantiation of the need for programs of prevention, early detection, and referral has been established in the Military Rejectee Program of the State Department of Health. A study of the 1,004 individuals disqualified in 1966 for military service indicated that knee injuries resultant from athletics were a major cause of rejection. This finding has resulted in new and increased attention to methods of prevention of injuries in school programs. Other leading causes of rejection such as obesity, hernias, hearing, cardiac, and back conditions could have been modified, had early detection and treatment been available.[60]

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[59] Building America's Health, America's Health Status, Needs and Resources, Vol. II.

Professional services such as psychological testing and evaluation are needed to identify problem individuals and those who exhibit pre-psychotic behavior patterns. Speech and hearing evaluations are necessary to identify problems which, if untreated, can substantially affect academic and vocational progress. Visual examinations are essential and can lead to the arrest of conditions resulting in visual impairment and blindness. Oberman reports an increasing prevalence of blindness and visual impairments and emphasizes the need for adequate detection and treatment programs.[61] Nadas and Zaver point out the ramifications of undetected cardiac problems in pediatric and adolescent patients and the essential nature of early detection and care in the ultimate rehabilitation of this disability.[62] In the same report, Jezer points out the experience of Altro Workshop in assessing the significance of extra cardiac conditions, notably length of illness, in rehabilitation success. Patients with periods of inactivity in excess of three years were found to be rarely rehabilitated, which was felt to be indicative not only of the severity of the organic disease but of other factors, primarily of an emotional nature. This finding suggests as does that of Aagaard,[63] that if the degree of disability is to be minimized, rehabilitation should begin as soon as possible.

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[60] Montana Health Referral Services for Medical Rejectees, Progress Report, Montana State Department of Health, July, 1966.

[61] Oberman, J. W., "Vision Needs of America's Children," The Sight-Saving Review, 36:4:217-226, Winter, 1966.

[62] Zaver and Nadas, op. cit., p. 71.

It is necessary that the identification of disability be highly effective in order that rehabilitation can begin very shortly after onset, since the physical and emotional degeneration which occurs can rapidly become irreversible.

Muller summarizes the widespread inadequacy of current health practices in preventative rehabilitation when he cites the functions of rehabilitation as requiring: (1) an extended concept of rehabilitation from a vocational orientation to one of prevention; (2) programs to assist other health workers to move beyond the narrow confines of a disease oriented approach to a functional concept of rehabilitation; and (3) the encouragement of comprehensive and continuous health services as the basis of sound rehabilitation.[64]

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[63] Aagaard, G. N., "Rehabilitation," Northwest Medicine, 57:8:997-1000, August, 1958.

[64] Muller, J. N., "New Concepts for Rehabilitation - A Preventative Medical View," Journal of Rehabilitation, 29:2:39, March-April, 1963.

RECOMMENDATION 16

IT IS RECOMMENDED THAT LOCAL SCHOOL DISTRICTS ESTABLISH NEW PROGRAMS, OR EXPAND EXISTING PROGRAMS, OF SPECIAL SERVICES AND CLASSES FOR CHILDREN WITH SIGNIFICANT PROBLEMS OF A PHYSICAL, EMOTIONAL, OR EDUCATIONAL NATURE.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	SCHOOL DISTRICTS DEPARTMENT OF HEALTH DEPARTMENT OF PUBLIC WELFARE OFFICE OF ECONOMIC OPPORTUNITY DEPARTMENT OF PUBLIC INSTRUCTION MENTAL HEALTH AUTHORITY

STATEMENT OF THE PROBLEM:

The movement toward development of special programs to meet the needs of exceptional children has received considerable impetus through federal programs, notably under Title VI of the Elementary and Secondary Education Act of 1965, as amended. Responsibility for such development is vested in the office of the Superintendent of Public Instruction, Special Education Department.

Extra financial assistance through the school foundation program is provided the school districts that have special educational programs. The formula provides essentially three times the regular payment for special education classes.

The number of handicapped children who were enrolled in public school special education programs during the 1965-1966 school year, are listed in the following table by major handicapping conditions:[65]

TABLE 7. NUMBER OF HANDICAPPED CHILDREN
IN
SPECIAL EDUCATION PROGRAMS -
BY HANDICAPPING CONDITION

Trainable Mentally Retarded	Educable Mentally Retarded	Speech Impaired	Hard of Hearing	Speech, Hearing Impairment	Crippled	Other Health Impaired	TOTAL
39	628	383	12	7	61	3	1102

As of the close of the school year 1967-68, there were 687 elementary and 168 high school districts in Montana. This number is expected to decrease by ten within the next year, due to annexation and other reasons. Of this vast number, only 41 of the districts operated state-approved special education programs. On the basis of a survey conducted on a random basis in 14 schools by the Supervisor of Special Education, it was found that 625 children of a total school population of 6,167 surveyed, were reported to be handicapped. On the basis of these figures, 20,014 school-age children are estimated to be handicapped in the state. These figures closely approximate national incidence figures which, when applied to Montana, could indicate 20,899 or 10.60% of the children to be so considered. The estimated cost to provide adequate educational services to all handicapped children in the state is $6,867,000.00.

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[65] Montana State Department of Public Instruction, State Plan to Initiate, Expand, and Improve Programs and Projects for the Education of the Handicapped Children, under Title VI of the Elementary and Secondary Education Act of 1965 as amended, February 6, 1968.

COMMENTS:

The basis of the treatment of the disabled child and the ultimate effects it has on total life adjustment, often is formulated during the school years, and availability of special education programs is crucial. The benefits of medical treatment, counseling, and therapy can be negated if special concern is not extended by the school for the educational problems which may be evidenced as a facet of the disabling condition. Experience has demonstrated that, whenever possible, the education of the exceptional child should be accomplished in as normal an environment as can be provided, rather than in an institutional setting. Some conditions of disability lend themselves to education in a regular classroom under the guidance of a knowledgeable and understanding teacher. Other conditions, because of their complexity and the special educational techniques required, demand special classrooms. Both approaches must then be considered in the determination of suitable educational programs. In either case, maximum social integration must be achieved with children in the regular classrooms. Hamilton, in referring to the epileptic child, observes that some epileptic children require special school auspices, even when optimum medical services have been supplied, but many can be taught in regular classes if more effective orientation of teachers in the handling of the seizure victims is provided.[66] The child with cardiac disease should, whenever his intellectual capacity permits, be placed in a regular school setting and be permitted to participate in non-competitive physical activities to the level of his tolerance.[67]

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[66] Hamilton, L., Bernd, J., "Education," Rehabilitation of Seizure Patients; One Day Institute, November 17, 1959, sponsored by...and the Montreal Neurological Institute in Cooperation with the Department of Neuro-Psychiatry, Hotel Dieu, pp. 17-21.

[67] Zaver and Nadas, op. cit., p. 146.

Local school boards ultimately have the responsibility for the establishment of adequate programs to meet the needs of the disabled child as well as the non-disabled, and this responsibility extends to secondary schools as well. Cooperative special education - Vocational Rehabilitation programs are an effective means of bridging the gap between the school and the community.

Frankel discusses special school programs which emphasize pre-vocational training beginning at the elementary school level, and points out that in view of the fact that mentally retarded children need more rather than less preparation for adult life, that it is unfortunate that less than 10% of them remain in school through the twelfth year.[68] Generally speaking, the school districts have not adjusted their programs to meet the needs of the disabled child in Montana.

Programs of benefit to the disabled child include: work experience programs, pre-vocational programs, guidance and parental educational programs, personal development programs, and home economics programs.

RECOMMENDATION 17

IT IS RECOMMENDED THAT THE EMPLOYMENT OF, OR CONTRACTING FOR SERVICES OF, TRAINED PERSONNEL BE AN INTEGRAL PART OF PROGRAMS DEVELOPED IN THE SCHOOLS TO ASSIST THE EXCEPTIONAL CHILD IN ORDER TO ASSURE THAT SUCH PROGRAMS ARE IMPLEMENTED AND DEVELOPED EFFECTIVELY.

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[68] Frankel, W. A., "The Role of the Workshop in Relation to Special Education," Work Evaluation and Employment Preparation Services for Mentally Retarded Adults: A Report on the Institute on Sheltered Workshop Services for the Mentally Retarded, University of Kansas...February 5-6-7, 1961, pp. 38-39.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DEPARTMENT OF HEALTH DEPARTMENT OF PUBLIC INSTRUCTION OFFICE OF ECONOMIC OPPORTUNITY MENTAL HEALTH AUTHORITY

STATEMENT OF THE PROBLEM:

The recognition that problems of disabled children exist and require attention is but the starting point for program development. The complex problem of disability as experienced in the educational systems of the state can only be resolved through the employment of trained individuals who have a primary responsibility for special program development. It is not adequate to assign responsibility of meeting the unique needs of the exceptional child to staff members who must afford him a low priority because of other demands upon them, or to staff members who do not have the necessary professional skills.

Trained personnel in the fields of special education, speech therapy, psychology, and counseling are in short supply; however, the development of methods for providing high quality services through the better utilization of trained persons is essential. Utilization of existing trained personnel in a supervisory capacity for those staff members with minimal training should be considered in preference to having minimally trained persons assume total responsibility for individual cases.

When personnel shortages do not permit the independent employment of trained persons by a school district, consideration should be given to the sharing of these persons between districts on a contractual basis.

Specialists are also needed to deal with visual problems, mental retardation, visual difficulties, speech, hearing, and other problems encountered in a classroom setting.

The sensitivity required to develop and provide service programs for exceptional children demands personnel with proper training, be it attained by a complete academic program, or through in-service training.

COMMENTS:

The acute shortage of trained personnel, particularly in sparsely populated areas, has resulted in a program in Montana which offers professional services to schools in a ten-county area. The Pupil Personnel Services Project serving Glacier, Toole, Liberty, Hill, Blaine, Phillips, Valley, Pondera, Teton, and Chouteau Counties offers services to schools through three centers at Big Sandy, Harlem, and Conrad. The staffs of trained psychologists, social workers, counselors, and reading specialists will soon by joined by speech therapists. Services are primarily of a diagnostic and consultative nature at this time, with individual and group counseling being provided when feasible. Consultation with school personnel can result in specially developed, individual programs to meet the highly unique needs of the exceptional child.

RECOMMENDATION 18

TO INSURE THAT ALL EXCEPTIONAL CHILDREN, REGARDLESS OF SCHOOL DISTRICT, HAVE EQUAL ACCESS TO SPECIAL TREATMENT AND EDUCATIONAL PROGRAMS, IT IS RECOMMENDED THAT A COMPREHENSIVE STUDY BE MADE OF EXISTING SCHOOL PROGRAMS, AND THAT STATE EFFORTS BE MADE TO CORRECT THE INEQUALITIES OF SERVICE AND OPPORTUNITY THAT CURRENTLY EXIST FOR SUCH CHILDREN.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	LEGISLATURE DEPARTMENT OF HEALTH OFFICE OF ECONOMIC OPPORTUNITY DEPARTMENT OF PUBLIC INSTRUCTION MENTAL HEALTH AUTHORITY

STATEMENT OF THE PROBLEM:

The inequality of the availability of special school programs for the exceptional child in many parts of the state is readily apparent when it is considered that of the 855 elementary and secondary school districts, only 41 offer special education of some type. The majority of classes are for the mentally retarded child with 39 districts offering classes for the educable retarded, 4 for the trainable retarded, 2 for the cerebral palsied and orthopedically handicapped, 7 for those with speech problems, and 1 for the hard of hearing.[69] As would be expected, the larger communities offer most of the special classes, but, increasingly, smaller districts are becoming cognizant of their responsibilities in these areas and are implementing programs.

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[69] Department of Public Instruction, Montana Special Education Teachers 1967-68 Directory, Preliminary List, State of Montana.

Even in the larger communities, programs are not available for many of the different disability categories. Missoula, for example, has 5 classes for the educable mentally retarded (EMR) child, none for the trainable (TMR), 1 for the speech handicapped, and 1 for the hard of hearing. Butte has 5 classes for the EMR, 1 for the TMR, and none for the speech handicapped or the hard of hearing child. Great Falls has 9 EMR classes, no TMR classes, and 1 for the cerebral palsied or orthopedically handicapped child. Billings has 10 classes for EMR children, 3 for TMR children, and 1 for the cerebral palsied and orthopedically handicapped. The directory does not indicate the existence of any special classes in Montana for the child with learning disabilities, nor for the emotionally disturbed child. There are 197,576 school children in Montana, and of the 20,014 considered to be in need of special education, only [illegible] in a select few areas are able to gain full benefit from the public school programs that currently exist. The majority of programs are at the elementary level and, with the exception of cooperative work-study programs, little is being done at the secondary school level.

COMMENTS:

The state plan for Elementary and Secondary Education Act of 1965, Title VI, acknowledges the need for changes in state legislation to extend services to those with learning disabilities, and suggests the need for a comprehensive legislative review in this area. The 1966 Biennial Report of the Superintendent of Public Instruction, State of Montana, recommends:

1. That increased recognition be given to the special educational needs of handicapped children, and that opportunities available to these children be broadened through provision of increased services and state financial aid for special education.

2. That education of children younger than six years be recognized not only as a worthwhile expenditure of public funds but as an important opportunity to increase the value of the investment that later will be made in their education. Statutory provision especially should be made to permit the early education of handicapped children by local school districts, and the provision should be repealed which now prevents the State School for the Deaf and Blind from accepting children under five years of age.

The scope of the problem, and the implications of program deficiencies for the handicapped child and his family, require an immediate and comprehensive study. Texas has a comprehensive educational-vocational program for the educable mentally retarded which is geared to smooth the way for more retardates from ages 6 to 21, from school into vocational training and ultimately competitive employment. A seven-step program from pre-primary school activities through eventual placement by vocational rehabilitation is substituted for the traditional twelve grade educational program.[70] Such innovative programming as exemplified by that program should be considered for all disabled children in Montana.

Moses in discussing a rationale for providing counseling to the handicapped high school student makes two assumptions which have validity in the entire field of special education and rehabilitation:

(a) every societal member has an inherent right to the opportunity to earn a living and

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[70] Eskridge, C. S., Partridge, D. L., "Vocational Rehabilitation for Exceptional Children through Special Education," Occupational Information for the Mentally Retarded: Selected Readings, pp. 396-406, 1967.

> (b) society has an obligation to equalize, as best it can, the disabled person's opportunity to earn a living equal to the opportunity of the non-disabled.[71]

An equitable educational system provides a logical starting point.

RECOMMENDATION 19

ALL CHILDREN SHOULD ATTEND SCHOOL. IT IS RECOMMENDED THAT LEGISLATION BE ENACTED PROVIDING THAT LOCAL SCHOOL AUTHORITIES APPOINT THREE OR MORE PROFESSIONAL PERSONS TO DECIDE WHETHER OR NOT A HANDICAPPING CONDITION PREVENTS THE CHILD'S ATTENDANCE AT SCHOOL. THESE PERSONS SHOULD BE REPRESENTATIVES FROM MEDICINE, EDUCATION, AND THE SOCIAL SERVICE PROFESSIONS.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	DEPARTMENT OF PUBLIC INSTRUCTION LEGISLATURE

STATEMENT OF THE PROBLEM:

ARTICLE XI. EDUCATION. Section 7 of the Constitution of the State of Montana states:

> The public free schools of the state shall be open to all children and youth between the ages of six and twenty-one years.

Section 75-1401, Revised Codes of Montana, 1947, defines the "Exceptional child" as:

> One requiring special facilities or instruction because of physical, mental, emotional, or moral deviation from the average.

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[71] Moses, H. A., "A Rationale for Providing Counseling for Handicapped Students," Journal of Rehabilitation, 32:6:14-15, November, December, 1966.

Section 75-2901, states in part:

> School attendance shall begin within the first week of the school term, unless the child is excused from such attendance by the superintendent of the public schools, in city and other districts having such superintendent, or by the clerk of the board of trustees in districts not having such superintendent, or by the principal of the private or parochial school, upon satisfactory showing either that the bodily or mental condition of the child does not permit of its attendance at school, or that the child is being instructed at home by a person qualified, in the opinion of the superintendent of schools in city or other districts having such superintendent, to teach the branches named in this section; provided, that the county superintendent may excuse children from attendance upon such schools where, in his judgment, the distance makes such attendance an undue hardship. In case the county superintendent, city superintendent, principal, or clerk refuses to excuse a child from attendance at school, an appeal may be taken from such decision to the district court of the county, upon giving a bond, within ten (10) days after such refusal, to the approval of said court, to pay all costs of the appeal; and the decision of the district court in the matter shall be final. Any parent, guardian, or other person having the care or custody of a child between the ages of seven (7) and sixteen (16) years, who shall fail to comply with the provisions of this section, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined not less than five dollars ($5.00) nor more than twenty dollars ($20.00).

Section 75-1406. Crippled children - home instruction - transportation - tax levy.

> The board of trustees of any school district, at its discretion, is authorized to assist the education of crippled children of five (5) to sixteen (16) years of age, who, because of physical handicap cannot regularly attend public school by furnishing home tutorial service for such crippled children or by furnishing transportation to and from adequate school facilities locally or elsewhere within the state, whichever best meets the child's needs as determined by the said board of trustees together with the superintendent of schools based upon recommendations of the division of service for crippled children of the Montana state board of health, and if in any school district there is a need

> of such special provision for crippled children located therein then the board of county commissioners may levy a tax not to exceed one (1) mill on the dollar on all taxable property, within the district, in addition to all other levies, for school purposes, for the support and maintenance of such crippled children's education, provided that the board of school trustees of any such district requiring such levy must call an election in the manner prescribed by law for such extra levies for the purpose of obtaining the approval of the district to the making of such additional levy and provided further that such election must be held before the 1st day of July.

The wording of the above cited laws as underlined would seem to allow latitude in assessing ability to attend school to the degree that the severely handicapped child would not receive the benefit and right to classroom attendance.

The laws of Montana adequately consider the needs of certain exceptional children once school admission is granted, but could be enhanced by broadening the language of Section 75-5004, Section 75-5005, and Section 75-5006 to read: "Mentally retarded, physically handicapped or emotionally disturbed."

Similarly, questions are raised regarding the language of Section 75-5003 which requires that special classes be formed by the board of trustees in each school district when there are not less than 10 exceptional children within that district. In Montana, with its large rural population, it is not unreasonable to assume that this eliminates the ready development of special programs for many exceptional children.

COMMENTS:

The existing laws could be improved by:

1. Requiring that the determination that children can attend (Section 75-2901) be made in the same fashion as

required in Section 75-5003; that is, by the State Superintendent using medical, psychiatric, and psychological consultations and thereby make it less discretionary on the part of the local districts. The problem here is gaining admission to regular school, and not with the determination that special education is needed after admission. This screening process would seem to eliminate from school programs some of the most severely disabled.

2. Giving consideration to the children in smaller districts who may not, in aggregate, total 10.

3. Broadening the language of Section 75-5004, 75-5005, and portions of 75-5006 to read: "mentally, physically, or emotionally handicapped children."

A thorough legal analysis should be made of the laws pertaining to this recommendation to determine if additional legal interpretation would modify the need for new legislation.

RECOMMENDATION 20

THERE SHOULD BE AN INCREASE IN THE COOPERATIVE WORK-STUDY PROGRAMS FOR EXCEPTIONAL CHILDREN AT THE SECONDARY SCHOOL LEVEL. EXISTING PROGRAMS FOR THE MENTALLY RETARDED AND THE PHYSICALLY HANDICAPPED HAVE DEMONSTRATED THE VALUE OF THIS TRAINING AND ADJUSTMENT IN THE PLACEMENT OF YOUNG PEOPLE IN PRODUCTIVE POSITIONS IN THE COMMUNITY.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DEPARTMENT OF PUBLIC INSTRUCTION DIVISION OF VOCATIONAL REHABILITATION LOCAL SCHOOL DISTRICTS

STATEMENT OF THE PROBLEM:

It has long been recognized that many children do not progress satisfactorily in the regular school curricula, and many have extreme difficulty in transferring from the school environment to the world of work. This is particularly true of the mentally retarded and severely physically disabled. In the 1967-68 school year, just 41 school districts had special education programs, or about 5% of the total 855 districts.

COMMENTS:

Billings and Helena pioneered in school-work experience programs at the secondary level in Montana, and in the 1967-68 school year 11 schools had this program. This is a cooperative effort between the school and DVR, in which special education students divide their time between classroom studies and on-the-job training. School and work are interrelated in a structured manner so that the pupil can make a smooth, successful transition from one life area to another.

William J. Younie says that the educational-vocational continuum is based on the assumption that vocational competence is composed of many factors which must be provided for in an educational program, beginning in early school years. Such a continuum program provides for a continuity of the mentally retarded child's school experiences so that consistency of purpose is insured and a definite progression is made toward carefully specified goals. To be successful, such a program must:

(1) be designed for the retarded from the time of identification until placement in adult life;

(2) interrelate special education and vocational rehabilitation;

(3) stress sequence through the use of long and short range goals that are compatible;

(4) insist on excellence at all levels and provide for constant communication between levels;

(5) provide an outcome that can be clearly seen by child, parents and teacher.

The school-work study program is the last phase of the educational vocational continuum. Emphasis must be given to the school-work study program as a part of the continuous process, and to this end, teachers at all levels of the continuum must be aware of the program's structure, functions, and goals.[72]

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[72] Younie, W. J., (Ed.), Guidelines for Establishing School-Work Study Programs for Educable Mentally Retarded Youth, 70 pp., Virginia State Department of Education, Special Education Service, 1966.

RECOMMENDATION 21

THE PERSON DISCHARGED FROM STATE CUSTODIAL INSTITUTIONS BACK TO COMMUNITY LIVING REQUIRES ADEQUATE SUPPORTIVE AND THERAPEUTIC SERVICES IF A SATISFACTORY ADJUSTMENT IS TO BE MADE. PROGRAMS PROVIDING SUCH SUPPORT, INCLUDING FAMILY COUNSELING, MUST BE DEVELOPED IN THE COMMUNITIES.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	DEPARTMENT OF INSTITUTIONS DIVISION OF VOCATIONAL REHABILITATION

STATEMENT OF THE PROBLEM:

Transition from life in a custodial institution to a satisfactory and rewarding life in the community is a major problem in rehabilitation of institutionalized people. Quite often, the sudden change from a dependency status to one of independence is overwhelming for the vocationally handicapped. An individual leaving a hospital or other institution with a chronic disability is in need of professional help in overcoming the problems associated with the disability. Adjusting to changes in community life provides additional problems.

Ralph Notman says that factors in the community can prevent effective rehabilitation and these include: unavailability of a setting which will accept the patient with residual disabilities when these disabilities are not so great that hospitalization is required, and lack of access to resources which are transitional between a hospital-centered and a community-based existence. Provision for these needs must be made and the patient must be aware that resources will be available; otherwise, it is reasonable for him to settle for "hospital-based rewards" and to accept his dependence. Close collaboration between the hospital-based and community-based resources must be maintained, because the transition is extremely threatening for the patient, and discontinuity or impersonality in the referral process can make the transition impossible.

Another problem which the rehabilitation team must face is the role the family plays in the patient's successful or unsuccessful rehabilitation. The family who encourages pathology is often very difficult to work with and can be extremely destructive. Community agencies may be essential in minimizing the negative role the family may play, and in the absence of an interested family, their role becomes even more important in that they must support the patient's transition into the community.[73]

COMMENTS:

Community-based facilities and services may ease the transition from institution to community. One such facility is the halfway house. The New Horizon Halfway House for alcoholics in Helena is the only such facility now operating in Montana. Others are in the planning stage.

An effective program is the COVE (Community Oriented Vocational Education) project in the state of Washington. The COVE program is a sheltered living arrangement in the community for vocationally handicapped individuals who are in need of social and vocational retraining. At COVE, these individuals find a comfortable living situation where their basic needs of shelter, food, fellowship, and warm support are met. This permits their energies to be directed toward understanding and overcoming their vocational and social problems.

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[73] Notman, R. R., "Problems of Rehabilitation Program Development," Rehabilitation of the Mentally Ill; Social and Economic Aspects; a Symposium of the American Psychiatric Association, Sponsored by the...American Association for the Advancement of Science and the American Sociological Society...December 29-30, 1957, pp. 57-70.

From this setting, the client may sample competitive jobs in the community. He receives only a token wage, because the objective of the experience is vocational and social education, not remuneration. Each client has free choice regarding the kind of work he wishes to experience. He may try several occupations. After a realistic choice has been made and the client has demonstrated his capability to function competitively, he starts the job-seeking phase of the program. The program staff gives assistance in finding a job in his community.

Often a client demonstrates potential for a vocation in which he does not possess adequate training or skills. In these cases, DVR, which is a program sponsor, provides a training program to develop skills he needs to be employable. Following a client's discharge from COVE, there is an active follow-up program by staff members. This is an effort to give support to the client in his transition to competitive work and living.

RECOMMENDATION 22

AFTERCARE SERVICES FOR YOUTHFUL PATIENTS RELEASED FROM WARM SPRINGS STATE HOSPITAL SHOULD BE PROVIDED ON THE SAME BASIS AS SERVICES NOW BEING PROVIDED OTHER INSTITUTION DISCHARGEES.

SCHEDULE FOR IMPLEMENTATION: INTERMEDIATE

INITIATOR: DEPARTMENT OF INSTITUTIONS
DIVISION OF VOCATIONAL REHABILITATION

STATEMENT OF THE PROBLEM:

Problems confronting young patients released from a mental care institution are very similar to those faced by their peers returning to the community from other institutions. In addition, of course, is the continuing need for therapy and medication due to disability. Preparations for return to the community need to be initiated long before the patient is released, and where adequate plans have been made, early release is often possible. If the patient has a satisfactory home environment, it is necessary to work with the parents as soon as possible. When such an environment is not present, it is necessary to find foster or group homes, and to prepare to provide the functions normally assumed by parents. Continuous observation and counseling is needed to insure that the patient is progressing, or to determine if he needs additional institutional care. Often the mental patient is in need of private tutoring and additional help with school work. Like other dischargees, he needs guidance and assistance in leisure time activities. He needs help in adjusting to the community and the world of work.

COMMENTS:

Juvenile Aftercare has been highly successful with children released from the Pine Hills School, the Mountain View School, and the Montana Children's Center. During the 1966-67 fiscal year, 323 boys and girls were released to the Aftercare program. Just 59 were returned to the institutions for violation of their aftercare agreements, while 199 were granted discharges by the Department of Institutions. New counselors are being strategically located throughout the state, a situation which will strengthen the program and allow for improved individual attention.

The emphasis in the program is on the individual's responsibility, on pride of accomplishment, and on individual integration into the flow of community activities.

RECOMMENDATION 23

LOCAL AND COUNTY AUTHORITIES SHOULD BE ENCOURAGED TO EMPLOY PUBLIC HEALTH NURSES AND OTHER TRAINED SOCIAL SERVICE PERSONNEL TO PROVIDE BETTER SERVICES TO DISABLED CHILDREN AND ADULTS IN THE COMMUNITIES.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	SCHOOL DISTRICTS LOCAL AUTHORITIES

STATEMENT OF THE PROBLEM:

Recent health legislation stresses our nation's determination to provide all persons with adequate medical care. There are many indicators such as the draft rejection rate (in Montana - 24.4%) which points to inadequate care of the young, both in diagnosis and treatment. The work of public health nurses in the schools and the communities is an important factor in early detection and care of potentially handicapping conditions, and in referral to the proper agencies. In Montana, legislation allows school boards to employ school nurses, and county commissioners to employ county health nurses for duties pertaining to maternal and child health. The State Department of Health is designated to supervise and regulate school, county, and public health nurses in the performance of their duties and to make and enforce regulations pertaining to the nurses and their work.

Although they are authorized by law to employ public health nurses, 22 counties in Montana do not have this service and several have only part-time nurses.

COMMENTS:

The importance of public health nurses in the home, in public health clinics, in the school, in the community, and in industry has been proven wherever the service is available. Insofar as practicable, it should be available to all citizens.

RECOMMENDATION 24

FOSTER HOME CARE OR OTHER TRANSITIONAL LIVING ARRANGEMENTS SHOULD BE CONSIDERED FOR THOSE DISCHARGEES FROM WARM SPRINGS STATE HOSPITAL WHO REQUIRE SUCH SERVICES AS A MEANS OF RE-INTEGRATION INTO THE COMMUNITY.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	DEPARTMENT OF INSTITUTIONS DIVISION OF VOCATIONAL REHABILITATION

STATEMENT OF THE PROBLEM:

Adjustment from any dependent role in the hospital to an independent role of citizen and worker in the community is a very traumatic experience for many mental patients. This is particularly true if the patient does not have an environment which is understanding and supportive of his efforts. Lack of a good environment often impedes the patient's progress and may be responsible for his return to the institution.

COMMENTS:

Authorities believe that halfway houses or other transitional facilities are necessary for many mental patients to successfully re-integrate into the community.

Milton Greenblatt says that there are a number of advantages to the development of transitional facilities to ease the shock of movement from the hospital to the community for the mental patient. First, the patient's discharge can be arranged earlier in his clinical course if such facilities exist. Graded steps to final community responsibility can be developed to fill the patient's level of improvement and degree of "ego strength" at any given period. The patient can remain in contact with the hospital therapeutic program for a longer time and can receive its benefits until he is firmly rooted in the community. The hospital with transitional facilities is able to concern itself more actively with many aspects of community rehabilitation of its patients and will pay more attention to overall integration of hospital and community services. At the same time, greater participation and responsibility of the community in relation to the mentally ill will be fostered by the presence of transitional facilities, and these facilities can provide alternatives to hospitalization for certain new or relapsing cases.[74]

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[74] Greenblatt, M., "Transition From Hospital to Community," Rehabilitation of the Mentally Ill,...op. cit., pp. 117-118.

RECOMMENDATION 25

IT IS RECOMMENDED THAT EFFECTIVE WORKING RELATIONSHIPS BE DEVELOPED BETWEEN THE TWO STATE REHABILITATION AGENCIES, THE STATE CUSTODIAL INSTITUTIONS, AND THE AFTERCARE DIVISION OF THE DEPARTMENT OF INSTITUTIONS. JOINT STAFF MEETINGS ARE NECESSARY TO ESTABLISH WORKING AGREEMENTS, DEVELOP A COMMON PHILOSOPHY, AND TO PLAN EFFECTIVE REHABILITATION PROGRAMS FOR THOSE IN THE INSTITUTIONS AND DISCHARGEES INTO THE COMMUNITY.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DIVISION OF VOCATIONAL REHABILITATION DIVISION OF BLIND SERVICES DEPARTMENT OF INSTITUTIONS

STATEMENT OF THE PROBLEM:

The problem of providing adequate services to persons discharged to the community from the institutions is recognized by all the agencies whose primary responsibility is to assure the total adjustment of the disabled to a productive capacity.

Initial steps at the administrative level have been taken to delineate responsibilities of the respective departments in community placement and follow-up. It is recognized that the objectives of the Department of Institutions and the rehabilitation agencies are similar in nature, but differ in methodology because of inherent differences of basic responsibility. The effectiveness of both agencies will be enhanced with the development of a common philosophy which can best be effected by regular and continuous staff meetings of key administrators and counselors.

COMMENTS:

Aftercare or follow-up in the community has only recently begun to receive the attention it deserves as a crucial step in the rehabilitation process. The best of care and treatment in an institution may be negated if the individual is returned to the same environment which precipitated institutionalization. The custodial institutions themselves must be active participants in the follow-up or aftercare process, as rehabilitation programs must begin in the institution with the recognized objective that eventual community adjustment must occur.

Basic assumptions of aftercare programs are that the patient requires help in one or more areas following discharge, and that he is entitled to help as part of any treatment program which purports to be complete.

Special areas that must be considered as part of aftercare are vocational rehabilitation (which should begin in the institution), recreation, assistance in the daily routine of living, assistance with family relationships, and further treatment as required.

Without effective aftercare, the chronic, long-term, institutionalized individual has a minimal opportunity for complete adjustment and rehabilitation.

RECOMMENDATION 26

VOCATIONAL TRAINING FACILITIES THAT WILL CONSIDER THE NEEDS OF DISABLED AND OTHER LIMITED PERSONS SHOULD BE PROVIDED IN MONTANA.

SCHEDULE FOR IMPLEMENTATION:	INTERMEDIATE
INITIATOR:	LEGISLATURE STATE BOARD OF REGENTS LOCAL SCHOOL DISTRICTS

STATEMENT OF THE PROBLEM:

The recognition that vocational training is required for the able-bodied, non-college bound individual has received increasing attention in Montana in the past several years. Equal recognition has been given to those working with the disabled individual to the fact that often vocational training, as offered by many facilities now available, is not geared to meet the needs of individuals with limitations.

With the rapid growth in technological developments, the trend in curriculum for vocational training has been to upgrade from the trade level to the technical level. This trend tends to ignore the needs for training of a less technical nature for jobs not requiring highly technical knowledge, as well as the needs of individuals with some physical or mental limitations who do have considerable aptitude and potential.

It should not be necessary, as has occurred in the past, to establish standards of admission and performance for certain common trades and vocations at a level commensurate with those that are to be expected at the four-year college level in a vocationally-related field. Adaptations of programs to meet the needs of persons with limitations does not mean lowering standards, rather it requires setting standards at a realistic level which assures adequate training while considering the individual, his abilities, and the requirements of employment.

COMMENTS:

Vocational training is an absolutely essential service in rehabilitation, as well as in education generally.

Each component as represented by the school and the rehabilitation agency has different orientations which must be reconciled in behalf of the disabled person.

The opportunities existant in Montana at this time to develop meaningful vocational training programs for all citizens, including the disabled, are better than ever before. Recognition of total needs, including those of the disabled, in planning the area vocational school is vital, and the responsibility for the needs of the disabled is incumbent upon those planning the schools. The endless possibilities for productive programs through coordination of interests has been demonstrated in other states.

Borchert, reporting on a project in North Dakota, remarks on the success of a program which trained blind students with sighted students in a trade-technical school, and which ultimately drew students from such far away states as New Jersey, Florida, and Oregon.[75] Such innovative planning would tend to enhance the base of support for schools incorporating programs that would attract out-of-state students.

RECOMMENDATION 27

IT IS RECOMMENDED THAT FREQUENT INTER-STAFF TRAINING PROGRAMS BE CONTINUED AND EXPANDED AT BOTH THE STATE AND LOCAL LEVEL, AS A MEANS OF INSURING THAT COORDINATION BETWEEN THE DIVISION OF BLIND SERVICES, DEPARTMENT OF PUBLIC WELFARE, DIVISION OF VOCATIONAL REHABILITATION, AND PUBLIC HEALTH PERSONNEL CONTINUES IN ITS CURRENT SATISFACTORY MANNER.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	DIVISION OF BLIND SERVICES DEPARTMENT OF PUBLIC WELFARE DIVISION OF VOCATIONAL REHABILITATION PUBLIC HEALTH DEPARTMENT EMPLOYMENT SERVICE

STATEMENT OF THE PROBLEM:

The coordination of activities and programs by major public agencies has always been necessary to assure the continuity of services for the disabled person. Recent federal legislation has had the effect of stimulating rapid program changes which, in turn, have tended to obscure some of the administrative and functional boundaries of these agencies. The possibility of duplication of services between agencies is greater than at any time in the past. Concurrent with these developments has been the broadening of the traditional role and clientele of each agency to include individuals who can receive similar services from several agencies. The position in which the agencies are placed because of these rapid changes dictates that a high level of coordination be maintained, if each is to accomplish its mission of assisting the individual in the most expeditious and economical manner possible.

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[75] Borchert, C. R., "Blind Trainees Succeed in Industry," Rehabilitation Record, 7:5:32-36, September-October, 1966.

Inter-staff training sessions, if properly developed and regularly scheduled, can be an effective tool in maintaining coordination and cooperation.

COMMENTS:

The special expertise and competency that has been developed over many years of providing health, welfare, and rehabilitation by each of these agencies within their areas can be melded into an effective and comprehensive program, if clear understanding is developed as to the specific function each can provide in a comprehensive rehabilitation program.

Inter-staff training has been utilized by the Division of Vocational Rehabilitation and Division of Blind Services, by the Division of Vocational Rehabilitation and the Department of Public Welfare, as well as by the Division of Blind Services and the Department of Public Welfare. An expansion of such training programs to involve other agencies would be beneficial to all.

The pooling of available training funds would permit an upgrading of training staff and staff materials.

RECOMMENDATION 28

RESIDENCY REQUIREMENTS, WHICH NOW EXIST FOR SERVICES IN STATE WELFARE DEPARTMENTS, CONSTITUTE A BARRIER TO THE EFFECTIVE REHABILITATION OF THOSE DISABLED WHO MUST CROSS STATE LINES TO RECEIVE NECESSARY TREATMENT AND TRAINING. IT IS RECOMMENDED THAT ACTION BE TAKEN TO REMOVE THESE REQUIREMENTS.

SCHEDULE FOR IMPLEMENTATION:	LONG RANGE
INITIATOR:	FEDERAL GOVERNMENT STATE WELFARE DEPARTMENTS

STATEMENT OF THE PROBLEM:

Our increasingly mobile society has had an effect on the disabled in two major areas: (1) The indigent disabled child or adult can, by virtue of an interstate move by the family unit, lose public assistance benefits, and (2) The imposition of residency requirements tends to limit access to necessary treatment and rehabilitation services not available in his home state.

Montana, as a state with limited rehabilitation resources, must utilize the facilities of larger states for medical treatment of a specialized nature and for vocational training facilities. The fear of loss of the security provided by public assistance in the home state, through movement to a state offering opportunities for rehabilitation, has inhibited the development and acceptance of suitable long-range rehabilitation plans for welfare recipients.

The policy of some states to discourage the immigration of welfare recipients for rehabilitation training in their centers, creates undue hardship on the individual, often resulting in total disruption of the plan to the degree that future rehabilitation efforts are fruitless.

COMMENTS:

The fact that federal support of all programs is increasing to the point where the state share is minimal, is an indication that the imposition of arbitrary barriers to rehabilitation, such as resident requirements, has little validity. Such requirements were imposed when the large portion of program funds came from the state and served as a device to protect state resources for state residents.

The emphasis should become one of changing the individual's status from one of dependency to independence, and whatever available resources, wherever geographically located, should be brought to bear on that basic problem.

RECOMMENDATION 29

INDIVIDUALS WHO ARE REFERRED FOR REHABILITATION SERVICES ARE ACCEPTED OR REJECTED ON THE BASIS OF THE EXAMINING PHYSICIAN'S REPORT. THIS REPORT OFTEN REFLECTS THE EXAMINER'S INTERPRETATION OF THE RELATIONSHIP OF THE MEDICAL CONDITION TO A VOCATIONAL HANDICAP. IT IS RECOMMENDED THAT A STUDY BE MADE OF SUCH REJECTED CASES TO DETERMINE IF OTHER RELATED CONDITIONS CREATE PROBLEMS THAT REQUIRE ATTENTION.

SCHEDULE FOR IMPLEMENTATION: INTERMEDIATE

INITIATOR:
DIVISION OF VOCATIONAL REHABILITATION
DIVISION OF BLIND SERVICES
STATE BOARD OF HEALTH

STATEMENT OF THE PROBLEM:

The Division of Vocational Rehabilitation and the Division of Blind Services as programs that are concerned with the disabled individual who has a vocational handicap have, as a first step in the determination of eligibility, required a medical examination by a physician who is most often a family doctor. If additional examinations are required to determine the existence of a disability and the functional limitations that are resultant from it, the services of a specialist can be utilized, as requested by the examining physician or by the medical consultant of the state agency. In either instance, where a physical or mental condition is suspected, the physician examines the individual to determine:

1. The existence of a physical or mental condition.
2. The functional limitation imposed by the condition.
3. The course of treatment considered necessary to alter, alleviate, or eliminate the condition.

It is not generally understood by the examining physician, as has been determined by the responses received from the Physicians' Survey, that the vocational counselor and the medical consultant of the state agency make the determination as to whether the condition, as described by the examining physician, constitutes a vocational handicap. Factors affecting this decision, in addition to the condition and the limitation of function it imposes, are previous work experience, educational background, age, related physical or psychological factors, and other aspects that may relate to the individual's ability or inability to function within an economically productive setting.

In practice, however, this determination is modified to a considerable degree by the report of the examining physician. If a positive statement is made by the physician that the individual is not handicapped, the counselor frequently has no alternative but to accept such a statement on the basis of the medical evidence presented. Frequently, such a statement may be based on the physician's lay interpretation of the vocational aspects and demands of the current employment market, as they relate to the individual. It is unrealistic to expect the physician to therefore become a vocational expert, in addition to the many other skills he must possess.

COMMENTS:

The entire area of the relationship of the medical condition and the functional limitations that create a vocational handicap is the basis of eligibility for the Vocational Rehabilitation program, as applied to the physically and emotionally disturbed person. It is an area of mutual concern and uncertainty by the agency and the medical community. It is an area which requires clarification and understanding if the disabled person is not to be denied needed rehabilitation services. Two typical comments of physicians serve to illustrate this. The first comment follows: "One patient was sent (i.e., referred by physician) for what I thought were very good reasons. She had five children to support, had experienced a slow recovery from hepatitis, and had emotional problems. She should have had rehabilitation services, but was turned down. This will, in the end, cost the state more money." The opposite view and understanding of the program is illustrated by this comment: "It (DVR) should stop recruiting people for the program who have minor physical abnormalities and no actual handicap - many of the ones that come to me are in this category. Concentrate on those who really need it - rehabilitation of stroke, cancer, and cardiac cases particularly."

The physicians were asked, "Are you aware that your professional opinion is the major determinate in the action taken by the office of Vocational Rehabilitation?" "Yes" was the reply of 170, 159 said "no," and 45 did not respond. This indicates that a high percentage are not aware of their significance to the program. When asked, "Do you have any patients with emotional or social handicaps that might be more productive members of society if the above services (rehabilitative services of many types) were available to them?"--189 physicians indicated they did have such patients, 90 said "no," and 95 did not respond. A significant number of the respondents acknowledged that limitations are imposed by these other non-medically related conditions.

An intensive study of cases rejected due to non-eligibility for medical reasons would be very illuminating and would provide a sound basis for program modification. It would also clarify certain crucial areas, which ultimately should result in better services to the disabled and in a stronger, more effective, agency-physician relationship.

RECOMMENDATION 30

THERE IS A NEED TO DEVELOP PROGRAMS OF ACTIVITIES FOR THE LEISURE TIME OF CERTAIN EMPLOYED INDIVIDUALS WHO REQUIRE STRUCTURED SOCIAL SITUATIONS. THE MENTALLY RETARDED ADULTS OR THOSE DISCHARGED FROM INSTITUTIONS PLACED IN EMPLOYMENT IN THE COMMUNITY OFTEN HAVE NEED FOR SUCH ACTIVITIES.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	PRIVATE AGENCIES SERVICE CLUBS

STATEMENT OF THE PROBLEM:

The average worker spends 1/3 of his day in employment, 1/3 asleep and the remaining eight hours in leisure or non-productive (economically) pursuits. The effective utilization of this period of time constitutes a problem for many persons, but for the mentally retarded adult or institutional dischargee it can prove to be lonely and unrewarding. It more often can be a period when problems detrimental to rehabilitation can develop. The person who has spent a long period in an institution with structured activities throughout each day can, upon placement on a job in the community, have a difficult time filling this vacuum. Studies have shown that these non-working hours can provide the weakest portion of a total rehabilitation program.

COMMENTS:

Facilities and structured programs and activities if available to the communities could be effective in assisting the retarded individual or the ex-mental patient to adjust to community life and to develop meaningful relationships with members of the community.

Grob reports on the effectiveness of social, therapeutic clubs as a mechanism to provide support of this type to these persons. The Center House Foundation worked with ex-mental patients and provides social activities, outings and excursions, planned meetings, educational groups, art groups and other activities. Personnel consists of ex-patients and volunteers, as well as professional staff members. Success has been determined by the increased social-emotional adjustment of the members and the attainment of employability of 2/3 of the members.[76]

Similarly the Manhattan Aftercare Clinic found in studying recently hospitalized ex-mental patients that organized activity immediately following hospital release was needed.[77]

RECOMMENDATION 31

EXISTING LEGISLATION RELATING TO THE ELIMINATION OF ARCHITECTURAL BARRIERS IN PUBLIC BUILDINGS (SECTIONS 69-3701 TO 69-3719, REVISED CODES OF MONTANA, 1947) REQUIRES STRENGTHENING TO ASSURE COMPLIANCE WITH THE STANDARDS WHICH HAVE BEEN ADOPTED

SCHEDULE FOR IMPLEMENTATION: INTERMEDIATE

INITIATOR: LEGISLATURE

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[76] Grob, S., The Social Therapeutic Club: A Tool for Vocational Rehabilitation, Center House Foundation, 1966.

[77] Kantor, R. E., "Implications of Process-Reactive Schizophrenia for Rehabilitation," Mental Hygiene, 48:4:644-652, October, 1964.

STATEMENT OF THE PROBLEM:

House Bill 345 of Montana Session Laws 1965 (Section 69-3701 through Section 69-3719, R.C.M., 1947) sets forth standards to insure that public buildings would be usable by the disabled. However, the bill provided for exceptions which are open to interpretation.

> Section 1. Application of act. (1) The standards and specifications set forth in this act shall apply to all buildings and facilities used by the public which are constructed in whole or in part by the use of state, county, or municipal funds, or the funds of any political subdivision of the state. All such buildings and facilities constructed in this state after the effective date of this act from any one of these funds or any combination thereof shall conform to each of the standards and specifications prescribed herein except where the authority responsible for the proper construction for the particular governmental department, agency, or unit concerned shall determine, after taking all circumstances into consideration, that full compliance with any particular standard or specification is impracticable.

Responsibility for enforcement is stated in Section 19 as follows:

> Section 19. Responsibility for enforcement. The responsibility for enforcement of this act shall be as follows:
>
> (1) Where state school funds are utilized -- state superintendent of public instruction.
>
> (2) Where state funds are utilized -- state controller.
>
> (3) Where funds of counties, municipalities or other political subdivisions are utilized -- by the governing bodies thereof.

State school funds are not normally utilized in construction of schools. Many of the university buildings are self-liquidating and do not involve state funds.

COMMENTS:

The report of the National Commission on Architectural Barriers to Rehabilitation of the Handicapped says: "The Commission recommends that all states be urged to enact new laws or amend present laws so that the law will be specific and will be based on the standards issued by the United States of America Standards Institute. The legislation should include strong enforcement provisions and should provide for the establishing and financing of a small unit in a single state agency which is assigned full responsibility for enforcing the law."

RECOMMENDATION 32

A STATEWIDE BUILDING SURVEY SHOULD BE PLANNED AND CONDUCTED IN MONTANA TO ASSIST IN PLANNING FOR NEW STRUCTURES AND REMODELING OF EXISTING BUILDINGS TO MAKE THEM USABLE BY AND ACCESSIBLE TO THE HANDICAPPED.

SCHEDULE FOR IMPLEMENTATION:	IMMEDIATE
INITIATOR:	MONTANA ASSOCIATION FOR REHABILITATION

STATEMENT OF THE PROBLEM:

The majority of people, including those who direct, supervise, or influence the planning and building of public buildings, are apathetic concerning architectural barriers. This is largely due to lack of knowledge and effective publicity. Education is necessary if the problem is to be understood and if steps are to be taken to improve existing structures and plan effectively for new buildings.

It is also important to the handicapped that they know what facilities are provided for them prior to their going into unfamiliar surroundings.

COMMENTS:

A community survey of public buildings and the subsequent publication of a guide for the handicapped is an effective way of focusing community attention upon architectural barriers, stimulating interest in barrier-free construction, and at the same time providing a valuable service to the disabled individuals within a community.

In addition, the actual process of surveying buildings is an excellent way of introducing volunteers, on a first-hand basis, to the problems that architectural barriers present to the handicapped, as well as educating volunteers to the practical application of the United States of America Standards Institute specifications in planning barrier-free construction.

An intensive publicity campaign is an important part of the plans for a survey and guide, greatly increasing the educational impact of the project upon the community.

CHAPTER IV

STATE INSTITUTIONS AND AGENCIES

The patients, inmates, and students of the state institutions constitute a substantial number of the disabled persons who can benefit from vocational rehabilitation services. The changing concepts of treatment as a community-based function will modify the traditional role of the institution. However, for some time there will be many individuals who will require treatment and care in these facilities. There will remain a significant need for rehabilitation within them. The current needs of this population for vocational rehabilitation services are not being adequately met. Rehabilitation programs developed to meet the unique needs of such individuals have demonstrated considerable success as part of an overall treatment and rehabilitation program in many states. Persons, formerly considered to be totally dependent, have been returned to a productive status in their communities. Rehabilitation programs have shown marked gains in the past few years; however, many programs of demonstrated value can be initiated as resources of staff and funds become available.

Many of those in the institutions will not be self-sufficient because of the severity of the disability, age, marital status, or other reasons. Consequently, they cannot at this time be considered for vocational rehabilitation services.

The recommendations for rehabilitation services were elicited from the superintendents of Warm Springs State Hospital, *Boulder River School and Hospital*, *Montana Children's Center*, *Galen State Hospital*, *Mountain View School*, *Montana State Prison*, *and the Pine Hills School* as presented to the

Governor's Policy Board of the Planning Project by the Director of the State Department of Institutions, Edwin Kellner. Floyd McDowell, Superintendent of the School for the Deaf and Blind, met with the Policy Board relative to needs for rehabilitative services at his school. Other state institutions under the Department of Institutions are not included in the following table as their populations were not considered to be candidates for vocational rehabilitation (Montana Veterans' Home, Montana Center for the Aged) or were not functional during the period of this Project (Eastern Montana Facility for the Retarded at Glendive, Swan River Youth Forest Camp).

TABLE 8. NUMBER OF RESIDENTS AND DAILY PER CAPITA COSTS*
MONTANA INSTITUTIONS

Institution	Average # Residents	Per Capita Costs
Montana Children's Center	139	$ 6.09
Boulder River School and Hospital	860	5.54
Mountain View School	49.3	14.08
Pine Hills School	144	11.25
Montana State Prison	535.69	8.806
Galen State Hospital	137	21.68
Warm Springs State Hospital	1428	7.36
Total	3292	$ 12.11

*Source: Montana State Department of Institutions Report, 1966-67.

NUMBER OF RESIDENTS - SCHOOL FOR THE DEAF AND BLIND

Avg. # Deaf and Blind	Avg. # Deaf	Avg. # Blind
1	79	40

TABLE 9 - STAFFING PATTERNS - MONTANA INSTITUTIONS

	Warm Springs		Galen		Mtn. View		Pine Hills		Boulder		School for the Deaf and Blind		Children's Center		State Prison	
	C*	P*	C	P	C	P	C	P	C	P	C	P	C	P	C	P
Physicians	3	4	6	6	Contr		Contr		½	2	Contract		1	1	3	Con. 1
Therapists																
Physical		2							1	3						
Occupational	1½	6							1	2						
Speech		1							1	4						
Industrial	1½	2														
Recreational	9	10			1	4	1	3	4	6				1		
Nurses																
RN	23	40	14	14	1	1	2	2	5	15		1	1	1	1	1
LPN	15	40	15	15					2	30	1	1		5		
Attendants	310	450							160	360		1				
Teachers																
Academic					8	12	12		12	20	24	28	8	10	4	8
Vocational	1	2				5	10		1	4	3	4		4	4	8
Psychiatrists	9	15			MHC*		1						1	1		1
Psychologists	6	9				1	1		2	5						1
Social Workers	8	15			3	5	1	3	2	6			2	4	2	4
Counselors	5	10			15	25	3	6	1	4						1
Other Professional	5.6	11													1	1
Other Personnel							19	19								

*C - Current
P - Projected

*MHC - Mental Hygiene Clinic

Methods Used to Estimate Potential of Inmates For Vocational Rehabilitation Services

The estimates of the number of inmates with a potential for vocational rehabilitation services was based on the subjective judgment of Project staff and institutional personnel. A definitive assessment of potential of each of the 3,292 inmates of the state institutions obviously was not practical or possible. *It must be strongly emphasized that these estimates are to be considered very rough and therefore must be evaluated on that basis.* The actual determination of vocational potential must be left to an individual diagnostic and evaluative process by a team of professional persons with rehabilitation philosophy in the institutional setting. The screening process used in making this estimate is in opposition, therefore, to basic rehabilitation philosophy which is not to screen-out but rather screen-in those who have potential for greater self-realization and development.

Unless specifically noted, because of institutional or diagnostic differences, the group consists of those persons meeting these criteria:

1. Under 60 years of age.
2. An IQ of 50 or above.
3. Institutionalized less than 10 years.
4. Having a defined physical or mental condition, according to case records.

It was felt that generally those eliminated presented a minimal rehabilitation potential.

In the case of the School for the Deaf and Blind, it was considered that all 120 students could ultimately benefit from some rehabilitation services.

Warm Springs State Hospital

Warm Springs State Hospital, which began as a private institution in 1877, was purchased by the state in 1912. The purpose is to provide custodial care and treatment for the mentally ill residents of the state, who are committed by the courts.[1] As of November 14, 1967, the current patient load was 1,400 persons. Age range of the population was reported as several days old to 100 years. In addition to the primary mission of care and treatment, the staff offers other services including psychiatric evaluations for court authorities, psychiatric services to inmates of Montana State Prison and other institutions, care of severely retarded and physically handicapped children and patients with complicated medical and/or surgical problems. The alcoholic treatment unit offers a five-week treatment program. The Hospital implemented the Unit System in 1967; this consists of the Western Unit, the Central Unit, and the Eastern Unit.[2] Intake services include a general medical examination, psychological testing, social service interview, and neurological and psychiatric examinations.

An in-service training program for personnel is now in effect, and employees who upgrade their skills receive a raise in grade as compensation.

The institution has no patient follow-up services, but must utilize other agencies for this important function. The services currently provided by the Division of Vocational Rehabilitation and the Division of Blind Services are not considered adequate to meet the needs of the patients at the Hospital. A full-time counseling service is requested, as well as an in-hospital rehabilitation program. Other services identified as necessary to rehabilitate more patients are halfway houses, sheltered workshops, and the proposed Comprehensive Mental Health Center facilities. The patient load is expected to drop as facilities for treatment become operational in the communities. The Warm Springs State Hospital is currently served by one counselor of the Division of Vocational Rehabilitation who has an office on the Hospital grounds but who also serves a general caseload of 150 disabled in three surrounding counties.

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[1] Department of Institutions, Report to the Governor, 1966-67, p.25.

[2] *Ibid.*

RECOMMENDATION 1

IT IS RECOMMENDED THAT A SHELTERED WORKSHOP FOR PATIENTS AT THE WARM SPRINGS STATE HOSPITAL BE DEVELOPED ON THE HOSPITAL GROUNDS, AND THAT THE INDUSTRIAL THERAPY PROGRAM BE INCREASED.

COMMENTS:

The need for a workshop facility on the grounds was cited by the Superintendent and staff as being of primary importance to the Hospital. Such a facility would provide an opportunity to evaluate patients within a simulated work setting and through application of test procedures. It would provide an opportunity for work experiences that many patients lack entirely; it would develop work and personal habits necessary for placement in employment in the community; and it would provide an opportunity for vocational training. Such a facility, utilized as an integral part of a total treatment and rehabilitation program, would greatly facilitate the discharge of patients into the communities. An on-grounds workshop could establish cooperative working agreements with the multiple-disability workshops which are contemplated in the larger communities. This would offer a transitional step in a workshop setting for those patients showing vocational potential.

Despite the fact that sheltered workshops for all disabilities have proven of value in rehabilitation, little has been done in Montana to stimulate the development of such facilities. In a survey of 490 sheltered workshops in communities of the United States, it was found that 90% of the 329 who responded indicated that they serve at least some clients whose emotional disturbance is not secondary to a physical disability. This same survey indicated that the one workshop in Montana reported that they had 16 physically handicapped and 3 emotionally disturbed persons. This, of course, is not remotely meeting the needs of either group in Montana. Workshops in 45 states responded to the survey, and Montana ranks 45th in the number of emotionally disturbed served per 100,000 in workshops.[3]

Multiple-disability shops are practical and most prevalent in the United States. Workshops within an institution tend, by their very nature, to be single-disability shops.

Hunt contends, as have others, that much of the disability resulting from mental illness is not intrinsic to the illness but is the result of certain extrinsic factors that can be remedied. Social rejection and the effects of institutionalization itself are contributing factors. He points out that even in a treatment-oriented institution, the patient experiences an increased amount of directed activity rather than opportunities to practice self-direction.[4] A workshop setting, coordinated with other treatment and rehabilitation programs and techniques, can offer much to patients at the Hospital in overcoming the negative aspects inherent in institutionalization.

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[3] Altro Health and Rehabilitation Services, Inc., Directory of Sheltered Workshops Serving the Emotionally Disturbed - Statistical Survey and Report, Kase, H. M. (Ed), VRA Research Grant, RD 1471, pp. 78-108.

RECOMMENDATION 2

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION PROVIDE SUFFICIENT COUNSELING STAFF TO FUNCTION WITHIN THE IN-PATIENT SERVICE OF THE WARM SPRINGS STATE HOSPITAL AND ALSO IN THE MENTAL HEALTH CENTERS AS THEY BECOME OPERATIVE. THIS WOULD REDUCE THE TIME BETWEEN REFERRAL AND INITIATION OF SERVICE AND WOULD ENABLE TESTING, PRE-PLACEMENT EXPERIENCES, TRAINING, JOB PLACEMENT, AND OTHER COUNSELING FUNCTIONS TO BE PROVIDED THE EMOTIONALLY DISTURBED PATIENTS.

COMMENTS:

At the present time, the Division of Vocational Rehabilitation counselor assigned to the Hospital also carries a general caseload in three counties and serves on an itinerant basis at the Prison and Galen as well. The Hospital staff indicates that the time interval from referral to acceptance can extend from one and one-half to two months. The nature of mental illness and the nature of institutional rehabilitation programs demands a counseling staff with small caseloads and special training.

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[4] Hunt, R. C., "Rehabilitation Potential of the Mentally Ill," Rehabilitation of the Mentally Ill; Social and Economic Aspects; A Symposium of the American Psychiatric Association, Sponsored by the...American Association for the Advancement of Science and the American Sociological Society, pp. 25-36.

The potential for an expanded Vocational Rehabilitation program is indicated by the number (500) currently in the Industrial Therapy work program at the Hospital. Job development and placement activities outside the Hospital constitute a major portion of adequate institutional rehabilitation programs. This service of Vocational Rehabilitation is very demanding of counselor time but is effective; to accomplish it adequate numbers of Vocational Rehabilitation counselors are needed. The Hospital staff estimates that six to eight vocational counselors could be effectively utilized at the Hospital.

A pilot study by Vocational Rehabilitation and an intensive treatment unit of a mental hospital was reported by Martin. He points out that rehabilitation in psychiatric illness deals with the patient's remaining abilities rather than his disability; therefore, the focus is upon developing assets. The project began in 1955, and an experienced Division of Vocational Rehabilitation counselor was assigned to the hospital staff. Through association with the social service division of the hospital, by reviewing cases, and attending staff conferences, a close working relationship was developed. The counselor became a vital member of the team, and shared decision-making responsibilities. This program resulted in more rehabilitation of psychiatric patients than any other single type of disability handled by the state agency that year. The program was therefore incorporated into the state Vocational Rehabilitation program.[5]

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[5] _Ibid._, Martin, H. R., "A Philosophy of Rehabilitation," p. 47-56.

TABLE 10. PATIENT CHARACTERISTICS

WARM SPRINGS STATE HOSPITAL

MALE Age	Acute and Chronic Brain Syndrome	Psychotic Disorders	Psycho-neurotic Disorders	Personality Disorders	Transient Situational Personality Disorders	Mental Deficiency	Without Mental Disorder	Totals
Under 5 yrs	12	0	0	0	0	1	0	13
5 - 17	56	2	0	0	0	22	1	81
18 - 19	4	2	0	1	0	2	0	9
20 - 44	43	92	0	21	0	39	1	196
45 - 64	57	166	2	17	1	24	1	268
65 and over	67	90	0	4	1	12	2	176
Totals	239	352	2	43	2	100	5	743
FEMALE								
Under 5 yrs	5	0	0	0	0	0	0	5
5 - 17	43	1	0	0	2	6	0	52
18 - 19	3	0	0	1	0	0	0	4
20 - 44	33	69	2	9	1	22	0	136
45 - 64	38	170	3	5	1	31	0	248
65 and over	86	84	6	1	1	10	0	188
Totals	208	324	11	16	5	69	0	633

NOTE: It was not possible to apply the criteria referred to previously due to the nature of the data received.

Galen State Hospital

Galen State Hospital has as its primary function the treatment of tuberculosis and silicosis, but has geared itself for treatment of other chronic respiratory diseases. In addition, a medical-surgical program is furnished for patients who are referred for care and treatment by other public state institutions. The Hospital also maintains a unit of approximately 100 beds for the care of mentally retarded who would otherwise be housed at the Boulder River School and Hospital, if space in that institution were available.[6] Admission to the Hospital is by physician referral and court commitment. Persons needing the services of the Hospital are admitted without regard to age. Intake services include medical and dental examination. Treatment is the sole program offered.

The patient load of 140 is expected to continue with little change to 1975. No formal follow-up service in the community is available to the discharged patient who has the option of returning to the Hospital for routine follow-up examination or contacting the family physician.

RECOMMENDATION 1

IT IS RECOMMENDED THAT MORE COUNSELOR TIME BE MADE AVAILABLE TO THE PATIENTS AT GALEN STATE HOSPITAL.

COMMENTS:

The counselor who now visits the Hospital has similar responsibilities to the Prison and Warm Springs State Hospital, as well as a general caseload.

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[6] Dept. of Institutions, Report...op. cit., p. 12.

Programming in the past has included vocational assessment, utilizing a formal evaluation technique. There is a definite need for training persons once an evaulation is made; otherwise, the patient often returns to the same environment in the community which was a factor in his requiring hospitalization.

The case review by Project staff and Hospital staff illustrates the apparent advantage in developing a closer relationship between the Division of Vocational Rehabilitation and Hospital staff to identify at an early stage potential candidates for Vocational Rehabilitation, and to extend Vocational Rehabilitation services to feasible cases who otherwise would not have access to services that the Hospital is unable to provide. An example is a patient who is a possible candidate for heart surgery after the arrest of the tubercular condition. Consideration should be given to the possibility of a Vocational Rehabilitation counselor sitting in on medical staffings as a resource person for other rehabilitation services.

The possibility of an alcohol treatment program should be considered because of the relatively high number of admissions who are reported to be alcoholics. The Alcoholics Anonymous program at Warm Springs State Hospital is not usable because of the possibility of tubercular contamination.

Characteristics of Patients Considered to Have Vocational Potential

Galen State Hospital

Male

Of the 27 patients whose records were reviewed at Galen State Hospital, 22 were male. Seven of these individuals are between ages 21-45, and 15 are between 56-64. Of these patients, 10 are married, 5 are divorced, 1 is separated, 1 is widowed, and 5 are single. A relatively high proportion of Indians was found, with 8 of that race, 13 Caucasians, and 1 identified as "other."

The review of the records indicated a generally stable employment history for this group prior to hospitalization. Of these, 13 were usually employed on a full-time basis, 2 were usually employed part-time, 3 were seldom employed, 1 had never been employed (because of age), and the employment histories of the other 3 were unknown.

The educational level of these males was well distributed in terms of years of education. One each had completed 4, 8, or 9 years of schooling, two had completed 10 years, two had completed 11 years, three had completed 12 years, and one had completed 13 years. All 22 males had a primary disability of tuberculosis but, in addition, had the following secondary disabilities: orthopedic - 2, arthritis - 1, visual impairments - 3, amputations - 2, cardiac condition - 1, diabetes - 1, alcoholism - 9, mental illness - 1, and 5 had other impairments. The relatively high proportion of multiple-disabilities was apparent in that eight of these individuals had three or more disabilities and five had two or more disabilities.

Female

Only five of the 27 patients considered to have rehabilitation potential were female. Three of them were in the 21-45 age range, one was between 18-20, and one was in the 46-64 age range. Two of them were single, two were divorced, and one was a widow. Of the five women, three are Indian and two are Caucasian. Their employment status prior to hospitalization was very diverse. One was considered to be generally employed part-time, one was never employed - although in the labor market, one was a student, and the employment status of the last patient was unknown. The educational level, with the exception of one individual, was rather limited. On two patients, the records do not show the level of education, one has 10 years of schooling, one has completed 9 years of schooling, and the last patient reported a total of 20 years of schooling.

All five are diagnosed as being tubercular and, in addition, one has a heart condition, one is an epileptic, and one has other disabilities. One of the individuals had a total of three disabilities, and another had two disabilities.

Mountain View School

The Mountain View School was established in 1893 and was originally part of the Boys' and Girls' Industrial School at Miles City. In 1919 it was transferred to its present site in Helena. The purpose of the school is to provide care, education, and rehabilitation for girls between the ages of 10 and 21 years who are committed by the Juvenile Courts.[7] These girls, in addition to having been adjudged delinquent, are often academically retarded. Intake services consist of social service interview, psychological testing, and counseling. Medical and dental examinations are provided by the school if not previously provided through the court. Institution programs include treatment, group therapy, basic education, and vocational training.

Staff in-service training was being planned at the time of the staffing pattern survey. No method of compensating employees who upgrade their skills is available. The inmate load of 68 is expected to increase slightly in the next two years. Community follow-up of discharged inmates is accomplished by the Aftercare Division of the State Department of Institutions.

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[7] Department of Institutions, Report...op. cit., p. 14.

The services of the Division of Vocational Rehabilitation are not considered to be adequate in meeting the inmate needs of the institution. Work programs in the community, with resident care provided by the school, are suggested. This function would capitalize upon the expertise and other services of Vocational Rehabilitation.

RECOMMENDATION 1

IT IS RECOMMENDED THAT A PART-TIME DIVISION OF VOCATIONAL REHABILITATION COUNSELOR BE ASSIGNED TO THE MOUNTAIN VIEW SCHOOL.

COMMENTS:

The services of a counselor, regularly scheduled at the institution on a part-time basis, should enable adequate services to be extended. Counseling and vocational training after discharge can be developed on an individual basis, with subsequent job placement and follow-up in the communities.

TABLE 11. PATIENT CHARACTERISTICS
MOUNTAIN VIEW SCHOOL

Total Number of Inmates - 55

Admission Age			Race			Educational Level			
0-5	6-17	18-20	Cauc.	Indian	Mex.	1-4	5-8	9-11	NR
0	55	0	30	22	3	0	29	25	1

IQ RANGE

Below 60	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130+	NR
2	3	5	11	16	7	0	0	5	6

DISABILITIES

Orthopedic	Arthritis	Visual	Amp.	Hearing	Heart	TB	Epilepsy	Speech	Diabetic	Other	NR
1	0	0	0	0	3	0	1	0	0	2	0

Montana Children's Center

The Montana Children's Center was established in 1893 for the support and care of the orphans, foundlings, and destitute children resident within the state. The primary function of the Center is the support and care of dependent or neglected children who require separation from their families or foster families or for whom foster care cannot be obtained.[8]

All children are admitted on the basis of court commitment; however, referrals emanate from physicians, welfare agencies, families, and probation officers. Age range is 6 to 20 years; however, those younger must be admitted if no other arrangements are possible. The children are, because of the circumstances which led to admission, physically and emotionally deprived and often evidence the effects of such loss. Intake services include medical and dental examination, social service interview, psychological testing where needed, and counseling. Center programs include limited treatment, group therapy, basic education, and work programs for selected children.

The staff does not have in-service training programs available to upgrade their competency. The current patient load of 147 children is expected to increase to 190 by 1975. The Center indicated that no follow-up services for discharged children were available. Halfway house facilities were suggested as a means of getting the individual back into the community.

RECOMMENDATION 1

IT IS RECOMMENDED THAT A DIVISION OF VOCATIONAL REHABILITATION COUNSELOR BE PROVIDED THE MONTANA CHILDREN'S CENTER ON A REGULARLY SCHEDULED BASIS.

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[8] Department of Institutions, Report...op. cit., p. 10.

COMMENTS:

The nature of the population at the Center in terms of age, problems, etc. is such that regular, itinerant service should be adequate to meet the present needs.

TABLE 12. PATIENT CHARACTERISTICS
MONTANA CHILDREN'S CENTER

Total Number of Residents - 147

Sex		Age at Admission				Race				Educational Level			
M	F	0-5	6-17	18-20	NR	Cauc.	Ind.	Mex.	NR	1-4	5-8	9-11	NR
78	69	15	129	0	3	97	43	2	5	30	77	15	25

IQ RANGE OF RESIDENTS

Below 60	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130+	NR
2	11	22	40	36	18	1	1	8	8

DISABILITIES

Orthopedic	Visual	Hearing	Heart	Epilepsy	Speech	Other	NR
3	1	12	1	2	5	7	116

Montana State Prison

The present Prison was developed as a territorial prison in 1867. The present walled compound was built in 1893 and 1894. The Prison and staff has as their primary responsibility the custody, care, and treatment of inmates convicted by the courts of Montana.[8] Both men and women, age 16 and over, are in custody. Intake services include medical examination, social service interview, counseling, and testing for job placement. Present programs include treatment, group therapy, basic education, limited vocational training, and a Prison work program.

In-service training is provided staff members. Current inmate population is 513, with projected increases to 600 in 1975. The Prison itself has no program for follow-up of discharged inmates. This aid is provided through the field officers of the Board of Pardons. Vocational Rehabilitation services are not considered adequate as service is provided on an itinerant basis by the counselor at Warm Springs. Vocational programs are limited to meat cutting and carpentry. Expansion of trade training is indicated. Halfway house facilities are considered necessary to effect satisfactory placement in the community for certain inmates.

RECOMMENDATION 1

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION EMPLOY A PERSON ON THEIR STAFF WHO IS TRAINED IN CORRECTIONAL REHABILITATION TO WORK WITH INDIVIDUALS AND TO DEVELOP COOPERATIVE PROGRAMS AT THE PRISON.

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[8] Department of Institutions, Report...op. cit., p. 19.

COMMENTS:

People, both in the correctional and vocational rehabilitation fields, have been aware that many offenders have serious physical and mental conditions. Much work has been done in the past in correctional rehabilitation in other states. It has been possible for several Vocational Rehabilitation agencies to bring the services of counseling, restoration, and training to those public offenders both in and out of institutions who otherwise would not have had access to them. Many demonstration projects have proven the efficacy of correctional rehabilitation programs. Oklahoma has had a cooperative project at McAlester which offers vocational training, group and individual counseling, and follow-up services after job placement.

RECOMMENDATION 2

IT IS RECOMMENDED THAT A STUDY BE MADE OF THE NEED TO INITIATE A SPECIAL PROJECT TO DETERMINE THE REHABILITATION POSSIBILITIES OF THE INMATES AT MONTANA STATE PRISON.

COMMENTS:

A pilot project could be initiated to screen the Prison population to assess individual vocational potential and to devise programs which would expedite placement of the dischargee in employment. Such studies are particularly valuable since correctional rehabilitation is an emerging field and new innovative programs are still needed. A report by Levis describes efforts of the Massachusetts Division of Vocational Rehabilitation and the correctional institution at Walpole to develop a rehabilitation program. Their experience indicated that problems relating to parole and other custodial considerations should be clearly worked out. He concluded that successful rehabilitation must start while the inmates are still in the institution.[9]

RECOMMENDATION 3

IT IS RECOMMENDED THAT STEPS BE TAKEN TO ESTABLISH FUNCTIONAL RELATIONSHIPS BETWEEN THE DIVISION OF VOCATIONAL REHABILITATION, DIVISION OF BLIND SERVICES, AND THE STAFF OF THE MONTANA STATE PRISON.

COMMENTS:

Interest in rehabilitation has been expressed by staff members at the Prison. However, no administrative-level meetings have been held with DVR and DBS to establish working relationships and to plan rehabilitation programs within the Prison. In addition to meetings of this type, it would be helpful in broadening the basis of mutual understanding and cooperation to have joint staff meetings and training sessions between the involved agencies and the Prison.

RECOMMENDATION 4

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION INITIATE AND CARRY OUT REHABILITATION PROGRAMS WITH THE CORRECTIONAL INSTITUTIONS, IN RECOGNITION OF THE PRESSING NEEDS OF THE INMATE POPULATION FOR SUCH SERVICES.

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[9] Levis, J., "Programs of Massachusetts Rehabilitation Commission in Rehabilitating the Penal Offender," Curriculum Materials Developed from a Conference on Effective Approaches to the Rehabilitation of the Disabled Public Offender, May 10-12, 1966, pp. 31-33.

COMMENTS:

Information gathered from the records of the Prison indicate that of the total population of 364 inmates, 268 have been identified as having problems which can be expected to have a relationship to their imprisonment. A study, done in 1964 by Emory University, gathered information on prisoners, parolees, and probationers at federal institutions in Florida and Georgia. This study indicated a substantial need for vocational rehabilitation among the 300 persons studied.[10] It could be anticipated that similar rehabilitation needs can be met within Montana State Prison if the Division of Vocational Rehabilitation develops cooperative programs at that institution.

TABLE 13. PATIENT CHARACTERISTICS
MONTANA STATE PRISON

Total Number of Inmates - 364

Age			Admittance Age							Race					
M	F	NR	Under 20	20-29	30-39	40-49	50-59	60+	NR	Cau.	Ind.	Mex.	Negro	Other	NR
345	16	3	51	178	79	36	15	3	2	252	85	6	5	7	9

Excessive Drinking				Drug Addiction				Occupation of Inmate				
Yes	No	Unknown	NR	Yes	No	Unknown	NR	Prof.	Skld.	Semi-Skld.	Un-Skld.	NR
232	91	31	10	26	207	99	32	2	29	82	231	20

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[10] National Rehabilitation Association, "The Research Effort," Rehabilitation Record, p. 27, November-December, 1965.

TABLE 13 (Continued)

IQ RANGE

Below 60	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130+	NR
3	9	16	15	18	21	14	5	2	261

Orthopedic	Arthritis	Visual	Amp.	Hearing	Cardiac Heart Stroke	TB & Resp.	Epilepsy	Speech	Diabetes	Other	NR
16	1	4	1	6	5	18	1	1	0	63	240

Educational Level				Prior Commitments							
1-4	5-8	9-11	NR	0	1	2	3	4	5	6	NR
33	182	82	67	169	123	45	13	4	1	1	8

Pine Hills School for Boys

This school was established in 1893 by the Legislature for the purpose of providing care, education, and rehabilitation for boys between ages 10 and 21, who have been committed by the Juvenile Courts.[11] Intake services include medical and dental examination, social service interview, aptitude testing, vocational testing, psychological testing, counseling, and religious orientation. Programs consist of group therapy, basic education, limited vocational training, individual therapy, and a work program.

Occasional in-service training programs are available for the staff, and immediate plans include counselor seminars and plans to train lodge parents. The current population of 116 is expected to remain relatively stable over the next ten years. Follow-up services are provided by the Aftercare Division of the Department of Institutions. The vocational rehabilitation needs of the inmates are not being adequately met; however, the establishment of a Division of Vocational Rehabilitation office in Miles City should alleviate this situation somewhat. Employment opportunities and job development are felt to be a critical need. Broadened criteria for Vocational Rehabilitation eligibility would be beneficial, as many at the School who could benefit from vocational services are not eligible on the basis of a physical or emotional condition.

RECOMMENDATION 1

IT IS RECOMMENDED THAT CONSIDERATION BE GIVEN TO THE DEVELOPMENT OF CERTAIN VOCATIONAL TRAINING PROGRAMS AT THE PINE HILLS SCHOOL.

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[11] Department of Institutions, Report...op. cit., p. 16.

COMMENTS:

A complete institutional rehabilitation program has many components. However, vocational training, either on the grounds or at an accessible trade school, is invaluable in preparing a person for a self-sufficient, law-abiding existence upon discharge. A project in Oklahoma utilized effectively a program of one-half a day in academic work and one-half in vocational training. The training program had to be restructured to shift emphasis from production to training. In addition to using training stations of an on-the-job training type, teaching aids were purchased. Programs were arranged so that credit earned could be transferred on discharge to a regular trade school.[12]

TABLE 14. PATIENT CHARACTERISTICS - PINE HILLS SCHOOL

Total Number of Inmates - 131

Age at Admission			Race				Educational Level			
0-5	6-17	18-20	Cauc.	Indian	Mexican	NR	1-4	5-8	9-11	NR
0	129	2	77	46	5	3	3	69	41	18

IQ RANGES									
Below 60	60-69	70-79	80-89	90-99	100-109	110-119	120-129	130+	NR
6	10	17	23	27	16	2	3	17	10

DISABILITIES											
Orthopedic	Arthritis	Visual	Amp.	Hearing	Cardiac	TB	Epilepsy	Speech	Diabetes	Other	NR
21	1	42	0	1	2	4	0	2	5	6	47

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[12] Oklahoma Rehabilitation Service, Oklahoma State Reformatory, Rehabilitation of the Young Offender - A Cooperative Program of Correctional Rehabilitation.

Boulder River School and Hospital

Boulder River School and Hospital was established as a training school and hospital for the education, training, and care of sub-normal and epileptic persons. The purpose and the object of this school is the mental, moral, and physical education and training of sub-normal persons whose defects prevent them from receiving proper instruction and training in public schools.[13] Approximately 1% of admissions are by court order, but the majority is by voluntary commitment. The age range of the patients is from 4 to 68 years; the primary disability is mental retardation. Intake services consist of medical examination, social service interview, psychological testing, and parental counseling. Programs available, in addition to treatment, include group therapy, basic education, vocational training, work programs, speech therapy, physical therapy, and recreational programs.

The staff has available an in-service training program. The current 1967 average caseload is 884 persons, and it is estimated that it will increase by 1975 to 1,200 persons. This increase is compatible with an increase of 300 in the past five years. Patient follow-up services in the community are provided by staff, and through the staff of other agencies. The present services, as provided by the Division of Vocational Rehabilitation and the Division of Blind Services, are not considered adequate to meet current needs. Cooperative programs between the Division of Vocational Rehabilitation and the Boulder School have been developed. Division of Vocational Rehabilitation funds have been utilized for vocational training of selected patients, remodeling of trade training facilities, and for a summer program whereby the Division of Vocational Rehabilitation sends retarded clients from throughout the state to the Boulder School for evaluation and short-term training. One counselor is assigned to work exclusively with the retarded in Montana, and the general counselors accept retarded as part of regular caseloads. Considering the number of retarded who could benefit from vocational rehabilitation, this arrangement has not been adequate to meet state needs.

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[13] Department of Institutions, Report...op. cit., p. 6.

RECOMMENDATION 1

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION ASSIGN A COUNSELOR TO WORK AT THE BOULDER RIVER SCHOOL AND HOSPITAL, AND THAT THE DIVISION OF BLIND SERVICES BE CONSIDERED FOR THOSE RESIDENTS MEETING ELIGIBILITY REQUIREMENTS.

COMMENTS:

Approximately 247 of 884 patients at the School fall within an IQ range of 50-99. These persons offer varying degrees of rehabilitation potential, if proper services and facilities are available. Other indicators of caseload potential are: 375 are considered to have potential to benefit from institutional school programs; 285 are considered candidates for institutional work programs; and 183 are considered able to be placed in the community, in the judgment of the staff. From 285 to 183 individuals seem to meet the general criteria which would enable them to benefit from some form of Vocational Rehabilitation services. A minimum of one full-time counselor seems indicated. Only 3 of the total of 884 are identified as having visual problems; therefore, services of the Division of Blind Services on an itinerant basis should be adequate.

RECOMMENDATION 2

IT IS RECOMMENDED THAT A PLACEMENT UNIT BE INITIATED AT THE BOULDER RIVER SCHOOL AND HOSPITAL TO DEVELOP PLACEMENT OPPORTUNITIES AND TO PROVIDE FOLLOW-UP TO DISCHARGEES IN THE COMMUNITY. THIS WOULD INCLUDE AN UPDATED INSTITUTIONAL TRAINING PROGRAM.

COMMENTS:

A unit on the grounds, especially geared to pre-release planning and programs, would greatly assist in placement activities. This could be a function of the School staff or could be incorporated as a function of the Division of Vocational Rehabilitation staff assigned to the School. Aftercare services are not adequate at the present time.

RECOMMENDATION 3

IT IS RECOMMENDED THAT AN EXPANSION BE MADE OF THE CURRENTLY SUCCESSFUL SUMMER PILOT PROGRAM OF THE DIVISION OF VOCATIONAL REHABILITATION, THE DIVISION OF BLIND SERVICES, AND THE BOULDER RIVER SCHOOL AND HOSPITAL.

COMMENTS:

This program expansion has also been requested by individuals in the community. The program offers the special competency and facilities of the School to retarded in the community. Retarded clients are now referred by general counselors of the Division of Vocational Rehabilitation. Those selected are provided a 13 week training program at the School, with the costs being paid by the DVR. At the completion of the summer program, the client has gained enough vocational and social competency to allow employment placement in the community by DVR. Thus far, results have been encouraging, and expansion of the program would enable many more retarded to be rehabilitated.

RECOMMENDATION 4

THE DIVISION OF VOCATIONAL REHABILITATION SHOULD ENCOURAGE THE DEVELOPMENT OF HALFWAY HOUSES TO ENABLE MORE RETARDED TO BE PLACED WITHIN THE COMMUNITY.

COMMENTS:

Halfway houses are an effective method to ease the transition of the institutionalized individual back into the community. This subject is explored more fully in Chapter VII, "Facilities."

TABLE 15. PATIENT CHARACTERISTICS
BOULDER RIVER SCHOOL AND HOSPITAL

Total Number of Residents - 130

Sex		Age				Race		
M	F	6-17	18-20	21-45	46-60	Cauc.	Indian	Mexican
84	46	57	18	54	1	119	9	2

Employment Status					Disability							
Full Time	Gen. Full-Time	Gen. Part-Time	Seldom	Never	Orthopedic	Visual	Cardiac Heart	Epilepsy	Speech	Diabetes	MR	Other
89	8	10	4	19	14	9	1	15	35	2	130	6

To the best of your knowledge, has this individual ever been in contact with DVR or DBS?

Yes	No	NR
1	127	2

Montana State School for the Deaf and Blind

The School for the Deaf and Blind was founded in 1893, and has as its primary purpose the education of the visually and acoustically impaired child in Montana who is unable to attend regular public school. The School, which is administered under the State Board of Education, admits children on the basis of physician, agency, school, and family referrals. The age range of the children in attendance is from 4 to 21 years. There is no lower age limit. Intake services include medical examination, social service interview, psychological testing, and counseling. In addition to basic education at the elementary and secondary level, group therapy, vocational training, and a work-study program are available.

An in-service training program is available to staff, and those upgrading their skills are compensated by salary increases. The current attendance is 120 students, of whom 40 are visually impaired, 79 are acoustically impaired, and 1 has both disabilities. Enrollment is expected to increase to 130 students by 1975. No follow-up services are provided graduates, except as needed and available through other agencies.

The Division of Vocational Rehabilitation is felt to be not adequately meeting the needs of the acoustically impaired child. However, the Division of Blind Services is meeting the needs of the visually impaired child through a program which stations a counselor at the School to work with this disability group.

RECOMMENDATION 1

IT IS RECOMMENDED THAT A VOCATIONAL REHABILITATION COUNSELOR, SKILLED IN WORKING WITH THE DEAF CLIENT, BE ASSIGNED TO THE SCHOOL FOR THE DEAF AND BLIND, AND THAT THIS COUNSELOR ALSO WORK WITH THE DEAF POPULATION OUTSIDE THE SCHOOL.

COMMENTS:

The handicap imposed by deafness creates a unique problem, primarily of a communicative and social adjustment nature, for which a specially trained vocational counselor is needed. The success of the program of the Division of Blind Services at the school is indicative of the gains to be realized by using a special approach. A program of a similar nature, geared to the special problems of the acoustically impaired, is indicated.

The Blind Youth Rehabilitation Project was begun in 1967, and involves the placement of a special Division of Blind Services counselor at the School. He works not only with the blind youngster at the School, but with the visually handicapped throughout the state. Services consist of home visits and case studies, counseling of child and parents, medical examinations, training and training materials, psychological testing, and evaluation.[14]

RECOMMENDATION 2

IT IS RECOMMENDED THAT CONSIDERATION BE GIVEN TO CHANGING THE LAW WHICH DELINEATES THE RESPONSIBILITIES OF THE SUPERINTENDENT OF THE SCHOOL FOR THE DEAF AND BLIND. THE RESPONSIBILITY FOR SERVING AS PLACEMENT OFFICER AT THE SCHOOL, FOR COORDINATING A CENSUS OF DEAF AND BLIND CHILDREN, AND FOR FULFILLING OTHER DUTIES CANNOT BE ADEQUATELY MET WITHOUT ADDITIONAL FUNDS AND STAFF.

COMMENTS:

The increasingly complex administrative duties of the office of the Superintendent of the School for the Deaf and Blind make it mandatory that either the responsibility for placement of children be removed from that office through cooperative agreements and establishment of working relationships with agencies, such as DVR or DBS, or that adequate funds and staff be provided the School so that this function can be carried out, as specified by law.

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[14] Montana School for the Deaf and Blind, The Rocky Mountain Leader, pp. 1-3, December, 1967.

State Agencies

Many public agencies which provide services to people have a direct relationship to, and interest in, the rehabilitation programs as provided through the Division of Vocational Rehabilitation and the Division of Blind Services.

These vocational rehabilitation agencies have, over the years, established effective working relationships with many of these agencies, and receive referrals of disabled from them. The understanding and coordination of programs on an inter-agency basis is becoming increasingly more complex because of changes in programs initiated at the federal level, and because of the changing requirements of the persons that all agencies serve.

The Policy Board of the Statewide Planning Project, in recognition of these facts, invited the administrators of the major state agencies to meet with them to determine the direction DVR and DBS should take to better meet the needs of the disabled.[15] Agency administrators responding to the invitation were:

W. J. Fouse, Administrator
Department of Public Welfare

John S. Anderson, M.D., Executive Officer
Department of Health

Harriet Miller, Superintendent of Public Instruction
(Represented by Roger Bauer, Special Education, DPI)

Jess C. Fletcher, Director, State Employment Service
(Represented by Robert Miller, Special Applicant Service, MSES)

Edwin Kellner, Director
Department of Institutions

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[15] See Appendix C for interview format.

Robert Swanberg, Chairman
Industrial Accident Board

W. H. Fredricks, Coordinator
Office of Economic Opportunity

J. C. Carver, Director
Division of Vocational Rehabilitation

Emil Honka, Director
Division of Blind Services

Floyd McDowell, Superintendent
School for the Deaf and Blind

The recommendations resulting from lengthy testimony at this meeting, February 15-16, 1968, are as follows:

1. The continued development of District offices by the Division of Blind Services, as a means of bringing better services more rapidly to the blind and the visually handicapped, is recommended.

2. It is recommended that a portion of the Aid to Needy Blind-Medical Services Program funds of the state be diverted to the Blind Services rehabilitation program to enable matching of federal rehabilitation funds, thus enabling more individuals to become rehabilitated.

3. It is recommended that inter-staff training programs be continued and expanded at both the state and local level as a means of insuring that coordination between the Division of Blind Services, Public Welfare Department, Division of Vocational Rehabilitation, and Public Health personnel continues in its current satisfactory manner. Such meetings should be frequent.

4. Rehabilitation and training programs for those individuals being discharged from state institutions should be increased as one method of reducing welfare costs.

5. It is recommended that residency requirements existing between states in welfare departments, which tend to create barriers to rehabilitation, be removed.

6. It is recommended that a facility be developed for the purpose of providing adjustment services and vocational training to the visually impaired. Such services, if properly planned, could be part of a multiple-disability facility.

7. It is recommended that steps be taken to reduce the time interval between referral of cases to the Division of Vocational Rehabilitation and contact of the individual by the DVR counselor, and that more follow-up services be provided clients by the counselor.

8. It is recommended that better screening procedures be developed for use prior to placement on jobs within the community of those released from Warm Springs and Boulder.

9. It is recommended that pre-vocational counseling by trained personnel be provided the handicapped in the schools.

10. It is recommended that the Division of Vocational Rehabilitation provide training and information to school counselors to insure better services to the disabled.

11. Cases referred for services are accepted largely on the basis of the examining physician's interpretation of the relationship of the condition to a vocational problem. It is recommended that a study be made of such rejected cases to determine if they have unmet needs as a result of other problems.

12. There is a need for development of rehabilitation plans for groups such as the retarded to consider and plan for the period of time when they are not functioning on the job; i.e., after working hours.

13. It is recommended that a team approach, utilizing the Division of Vocational Rehabilitation counselor and the Public Health Nurse at the community level, be implemented to assist in the community adjustment of those released from Warm Springs State Hospital.

14. It is recommended that the number of rehabilitation counselors be increased to enable better services to the rural disabled, and to work with the exceptional child after his school experiences are terminated.

15. Evaluation, diagnostic, and training facilities are necessary for both the disabled child needing sheltered employment and the child ultimately able to accept competitive employment.

16. Programs of information and education regarding disability should be directed at school personnel to enable them to more readily identify and refer children needing rehabilitative services.

17. It is recommended that psychological testing services be increased in the schools by attracting well-qualified professionals.

18. It is recommended that vocational training facilities be developed in Montana which will consider the needs of disabled persons.

19. It is recommended that formal programs to increase public understanding and acceptance of disabled persons be developed.

20. It is recommended that steps be taken to establish functional relationships between the Division of Vocational Rehabilitation, Division of Blind Services, and the staff of Montana State Prison.

21. It is recommended that the Division of Vocational Rehabilitation initiate and carry out rehabilitation programs with the correctional institutions, in recognition of the pressing needs of the inmate population for such services.

22. It is recommended that the Division of Vocational Rehabilitation employ a staff person trained in correctional rehabilitation to develop cooperative programs at Montana State Prison.

23. It is recommended that a study be made of the need to initiate a special project at the Prison to determine the rehabilitation potential of the inmates.

24. It is recommended that the Division of Vocational Rehabilitation provide sufficient counseling staff to function within the in-patient service of Warm Springs State Hospital and the Mental Hygiene Clinics as they become operative within the state. This would reduce the time between referral and service and would enable work to be done in pre-placement experience, testing, training, and job placement of patients.

25. It is recommended that sheltered workshops for patients at Warm Springs State Hospital be developed, and that the industrial therapy program be increased.

26. It is recommended that the socially disabled individual, such as those with whom custodial institutions work, be provided rehabilitative services.

27. It is recommended that suitable living facilities be developed for those discharged from the institutions into the community as a means of effecting a satisfactory transition back to the community.

28. It is recommended that a part-time Division of Vocational Rehabilitation counselor be assigned to the Vocational School for Girls.

29. It is recommended that more counselor time be made available to the patients at Galen State Hospital.

30. It is recommended that an expansion of the currently successful summer pilot program of the Division of Vocational Rehabilitation, the Division of Blind Services, and the Boulder River School, be made.

31. It is recommended that the Division of Vocational Rehabilitation assign a counselor to work at the Boulder River School, and that the Division of Blind Services be considered for those residents meeting eligibility requirements.

32. It is recommended that a placement unit be initiated at the Boulder River School to develop placement opportunities and provide follow-up services to dischargees in the community.

33. It is recommended that a series of meetings be initiated between the Division of Vocational Rehabilitation, the Division of Blind Services, and the staffs of the state institutions to establish working agreements, develop a common philosophy, and to plan effective rehabilitation programs for those in the institutions.

34. It is recommended that informational programs on mental retardation and sources of assistance be directed to the community and to those working with the retarded individual.

35. It is recommended that consideration be given to the development of certain vocational training programs at the Pine Hills School for boys.

36. It is recommended that a Division of Vocational Rehabilitation counselor be provided the Montana Children's Center on an itinerant basis.

37. Inter-agency working relationships should be clarified between the Division of Vocational Rehabilitation and the Aftercare Division of the Department of Institutions to insure that the responsibility for counseling is delineated.

38. It is recommended that a Vocational Rehabilitation counselor, skilled in working with the deaf client, be assigned to the School for the Deaf and Blind, and that this counselor also work with the deaf population outside the school.

39. It is recommended that consideration be given to changing the law which delineates the responsibilities of the Superintendent of the School for the Deaf and Blind. The responsibility for serving as placement officer at the School, for coordinating a census of deaf and blind children, and for fulfilling other duties cannot be adequately met without additional funds and staff.

Summary

The nature and severity of a problem which necessitates institutional treatment mitigates an accurate estimate of potential for rehabilitation on any basis but an individual case assessment and evaluation. General estimates can be made, however, by the application of criteria that tends to delimit the number of cases to those meeting the standards established.

This approach has been utilized for Project purposes and results, therefore, are a gross estimate of approximately 452 persons (excluding those at Warm Springs State Hospital) who are now residing in institutions referred to in this Chapter, and who are potential candidates for vocational rehabilitation services of some kind.

If a broader definition of eligibility for services, such as is now permitted by recent amendments to the Vocational Rehabilitation Act, is applied, then all those persons in Pine Hills School, Mountain View School, Montana State Prison, and the Montana Children's Center could be considered eligible by virtue of the social conditions and maladjustment resulting from institutionalization.

Present capabilities of funds and staff will probably preclude this approach to eligibility for some time.

No concerted effort has been made to develop comprehensive programs in the institutions by the vocational rehabilitation agencies for the reasons cited. Excellent beginnings have been made as resources permit. Outstanding examples are: the Swan River Youth Forest Camp, the cooperative Work-Experience program at the Boulder River School and Hospital, an evaluation project at the Boulder River School, and the

Blind Youth Project at the School for the Deaf and Blind. These programs indicate current Vocational Rehabilitation-Institution cooperation. In 1947, Montana, Vermont, and Colorado had the distinction of pioneering the first Vocational Rehabilitation programs in mental hospitals in the United States. Vermont and Colorado have continued to expand such programs.

The urgent necessity for liaison and coordination between the institutions and the vocational rehabilitation agencies at all levels was emphasized in meeting with the agency and institution administrators. Staff, while a critical problem for all departments, could be more effectively utilized through a clear delineation of function and responsibility, particularly in the areas of counseling and placement. The inadequate vocational training opportunities available in Montana for all disabled are especially acute when the needs of those discharged from the institutions and state schools are considered.

The advantages of having adequate numbers of trained Vocational Rehabilitation counselors stationed at the institutions were pointed out by all administrators, and have been amply demonstrated to be essential in other states. The problems, unique to Montana and other rural states, of low population density and limited resources, dictates that well-planned pilot or demonstration projects be considered as one means of providing adequate services to the disabled in the state.

The potential advantages of complete physical, psychological, and social evaluations on a uniform basis in the institutions were demonstrated by the difficulty of gathering similar data. The Western Interstate Commission on Higher Education project at the Boulder River School provided a considerable amount of pertinent up-to-date information for administrative and planning purposes. If similar systems could be incorporated in the other institutions, it would considerably enhance the treatment and rehabilitation programs in these facilities.

The notable gains made in Montana in recent years must be continued if comprehensive rehabilitation services are to be made available to those in the institutions.

CHAPTER V

THE DISABLED AND HANDICAPPED OF MONTANA

Planning to meet the present and future needs of disabled individuals necessitates that information, reflecting the extent and nature of the problem and the characteristics of the individuals to be served, be available to provide a foundation for program development.

Community Survey

Following a study by Project staff of the techniques that could be used in gathering meaningful information, with consideration for the limitations of staff time and funds, the Policy Board, staff, and consultants determined that a random household survey, which would be representative of the diverse and sparse population of Montana, was not feasible. Accordingly, a survey conducted in the communities of the state, utilizing the "grass roots" committee structure, was suggested. This method was felt to be advantageous in that it would: (1) identify those individuals whose disabilities were serious enough to present problems, as reported by major agencies and as verified by case records; (2) identify individuals with good potential for rehabilitation; and (3) promote community involvement with increased awareness of the problems of the disabled at the local level.

Method

An agreement was entered into with the Sociology Department at Montana State University to develop, in conjunction with Project staff, questionnaires to be distributed in the communities through the 13 district chairmen and the county chairmen.[1] A formal orientation meeting was held in each district by Project staff, with district and county participants and agency representatives in attendance, to explain the purpose of the survey and to cover methods to be followed in the distribution and completion of survey forms. In addition to utilizing a narrated slide presentation, written materials accompanied the survey materials. The completed questionnaires were mailed to the Sociology Department for IBM processing, tabulation, and elimination of duplications. (Tabulations were presented by county and statewide totals. The material was then compiled to compare to the five regions. These regions had assimilated the 13 districts originally serving as the functional structure of the Project.) Throughout Montana, 10,555 disabled individuals were identified by this survey.

It is recognized that the method used had limitations, as do all survey techniques, although it is felt that the survey was successful in identifying the particular population concerned in rehabilitation planning.

The primary source of survey information is derived from the case records of the major state agencies and from the schools in the state. This approach provided an identification of a group of individuals to whom rehabilitation services would be most beneficial and meaningful. Over 500 direct referrals to the Division of Vocational Rehabilitation and the Division of Blind Services resulted from this survey. Guidelines for the survey emphasized the vocational nature of the programs, and consequently had bearing on the types of individuals identified. This tended to exclude those not in the labor market because of age, unless supplementary employment was required to maintain adequate living standards.

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[1] See Appendix C.

Geographically, the percentage of individuals identified in each regional population was very uniform. It can be assumed that this is an indication that the method used adequately oriented survey participants to survey purposes and to the type of individuals the Project was seeking to identify. The application of survey procedures would also seem to have been quite uniform.

TABLE 16 - OVERALL SURVEY RETURNS

Region	1960 Population	Number Identified	Percent of Total Population
1	125,527	2,035	1.62%
2	147,636	2,111	1.43%
3	151,283	2,487	1.64%
4	144,698	2,260	1.56%
5	105,576	1,662	1.57%

These figures are considered to be conservative, as an indication of the number of disabled who could benefit from vocational rehabilitation. Some categories were not adequately represented - children not in school, severely disabled receiving care at home, and those without obvious conditions or conditions elusive of diagnosis such as hearing impairments, cardiac conditions, alcoholism, and mental illness.

Although participating agencies were in general very thorough in conducting the survey, it can be assumed that many disabled were not identified due to the voluntary nature of the task. This was evident in several individual counties.

The most important fact evidenced by the survey is that at least 1.5% of the state population, 10,555 individuals, are known to have disabilities which are substantial and which impose limitations. This compares with .25% of the population, 1,777, who received rehabilitation services from the two vocational rehabilitation agencies in fiscal year 1967-68.

The number of Montanans who could benefit from services, compared to those now receiving services, is indicative of the program activity needed in all phases of rehabilitation in the coming year.

CHARACTERISTICS OF
10,555 IDENTIFIED DISABLED AND HANDICAPPED
IN MONTANA

TABLE 17 - AGES BY SEX

Region	0-5		6-17		18-20		21-45		46-64		64+		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1	24	15	465	288	98	41	331	182	238	216	64	73	1220	815
2	31	28	455	322	79	54	321	164	324	181	78	74	1288	823
3	32	31	691	468	107	70	249	133	321	179	149	57	1549	938
4	71	53	784	509	90	40	159	125	182	96	58	93	1344	916
5	44	23	327	238	69	52	248	150	238	150	77	46	1003	659
TOTAL	202	150	2722	1825	443	257	1308	754	1303	822	426	343	6404	4151

COMMENTS:

Of those identified, 60.67% were male and 39.32% female, as compared to a sex ratio in the general Montana population of 50.73% male and 49.27% female. The 43% in the 6-17 age category is indicative of the future demands that will be placed upon rehabilitative services, as these children enter the labor market. This would tend to substantiate the need, not only for adequate treatment, but additional special education and work-study programs in the schools. It should be noted that, generally speaking, on a percentage basis of the total reported by age groups, Regions 1, 2, and 5 were very similar. Regions 3 and 4 showed a preponderance of those in the 0-17 group, primarily because of the large number of identifications by the schools in Region 3 and by Public Health in Region 4.

TABLE 18 - MARITAL STATUS BY SEX

	No Response		Single		Married		Separated		Divorced		Widowed	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	137	195	747	368	300	98	7	17	27	70	8	61
Region 2	0	10	778	460	368	141	25	36	73	80	33	107
Region 3	12	5	1009	621	380	141	19	26	89	61	37	87
Region 4	2	3	1067	646	202	79	15	13	40	84	11	98
Region 5	0	2	634	397	296	120	13	20	36	40	26	78
TOTALS	151	215	4235	2492	1546	579	79	112	265	335	115	431

COMMENTS:

Of those reported, 63.7% were unmarried, which is a reflection of the large number of young persons reported by the survey. There were 20.1% of the total reported as married, and the balance reported were separated, widowed, or divorced. The large number of "no" responses in Region 1, 16%, can be ascribed to the manner in which the questionnaire was completed by an agency reporting a large number of children. The majority of responses there would tend to increase the unmarried category of Region 1. Regions 2 and 5 reported the highest percentage of married disabled, 24% and 25% respectively.

TABLE 19 - RACIAL CHARACTERISTICS BY SEX

	No Response		Cauc.		Indian		Negro		Mexican		Other	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	26	17	968	539	217	254	0	0	3	3	3	5
Region 2	46	24	1000	652	223	143	5	2	5	1	9	1
Region 3	21	13	1470	882	25	36	3	0	21	6	8	2
Region 4	9	11	1161	804	121	75	2	1	46	24	3	3
Region 5	4	6	799	495	155	103	0	1	2	4	45	48
TOTAL	106	71	5398	3372	741	611	10	4	77	38	68	59

COMMENTS:

The total statewide percentage of Indians reported by the survey was 12.8% as compared to an Indian composition in the general Montana population of 4.5%. This may be substantiation of findings of other studies that the incidence of disability among Indians is higher than among Caucasians, or it may be a reflection of the reporting by the Community Action Programs on the reservations in Regions 1 and 5. Region 1 reported 23% Indian, and Region 5 reported 15.5%. In Region 2, which has the Blackfoot Reservation, 17.3% were Indian; however, the identification there was apparently made by public agencies on the reservation, other than the Community Action Program.

TABLE 20 - EMPLOYMENT STATUS BY SEX

	No Response		Full Time		Generally Full Time		Generally Part Time		Seldom Employed		Never Employed	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	153	203	100	6	119	22	141	30	111	73	594	483
Region 2	14	19	54	16	195	41	181	60	185	96	658	592
Region 3	22	13	122	32	224	59	105	45	133	64	941	727
Region 4	12	7	46	11	82	27	101	29	160	114	941	730
Region 5	11	3	73	14	82	21	130	40	188	104	521	475
TOTAL	212	245	395	79	702	170	658	204	777	451	3655	3007

COMMENTS:

It will be noted that the high number of those reported "never employed" is due to the large number of individuals under age 18 reported in the survey. On a percentage basis by Region, the range was 73.8% in Region 4 to 38% in Region 1, which also had the highest percent of "no response" answers, 17%. This is probably due to the same reason.

TABLE 21 - EMPLOYMENT BARRIERS BY SEX

	No Response		Definitely Yes		Possibly		Uncertain		Doubtful		Definitely No	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	178	208	496	173	273	81	81	31	84	26	113	295
Region 2	53	34	560	414	359	206	131	75	116	62	69	32
Region 3	23	13	514	320	538	283	257	175	147	105	70	42
Region 4	24	18	657	457	381	243	121	85	92	64	69	49
Region 5	17	11	588	403	264	164	73	48	26	17	37	14
TOTALS	290	284	2815	1767	1815	978	663	414	465	274	358	432

COMMENTS:

Statewide, 43.4% of those reported were felt to definitely have a barrier to employment due to the condition of disability, and 26.5% were judged to possibly have a barrier. Thus, 69.9% were judged to have employment problems related to the condition. The remaining 30.1% fell within the other categories. It is recognized that response to this question is on a highly subjective basis unless substantiated by history of unemployment in case records. This question is not relevant to the majority of cases reported by the schools, and is of doubtful relevance to those reported by other agencies, such as Public Health. The Employment Service, Public Welfare Department, and Community Action Program, by virtue of their case recording practices, can be considered to have substantiating information of this type available.

TABLE 22 - DISABILITIES BY SEX

	No Response		Orthopedic		Arthritis		Visual Impairments		Amputations		Hearing Impairments	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	4	3	165	70	46	111	94	53	36	11	66	49
Region 2	0	0	232	122	79	66	134	69	54	7	138	82
Region 3	4	2	230	149	76	55	141	76	42	14	137	72
Region 4	27	33	221	150	35	64	137	90	19	3	137	99
Region 5	4	1	137	81	49	65	114	72	26	6	99	52
TOTALS	39	39	985	572	285	361	620	360	177	41	577	354

TABLE 23 - DISABILITIES BY SEX

	Cardiac - Heart-Stroke		TB & Resp.		Epilepsy		Speech Impairments		Diabetes		Alcoholism	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	141	100	37	19	36	31	120	68	42	47	53	25
Region 2	120	92	57	17	45	47	127	83	40	42	89	41
Region 3	177	122	165	44	39	22	79	45	44	41	81	38
Region 4	114	90	68	36	67	44	168	97	32	25	51	13
Region 5	136	66	52	16	24	27	129	72	28	44	157	29
TOTALS	688	470	379	132	211	171	623	365	186	199	431	146

TABLE 24 - DISABILITIES BY SEX

	Drug Addiction		Mental Illness		Mental Retardation		Delinquency		Habitual Criminal		Other	
	M	F	M	F	M	F	M	F	M	F	M	F
Region 1	16	10	65	62	244	184	109	22	7	1	165	121
Region 2	1	1	72	78	213	182	26	8	8	0	186	131
Region 3	1	1	67	57	205	141	26	6	5	0	371	257
Region 4	5	0	76	57	351	213	66	15	2	1	155	118
Region 5	3	2	81	71	238	244	22	16	3	0	103	69
TOTALS	26	14	361	325	1251	964	249	67	25	2	980	696

TABLE 25 - DISABILITIES REPORTED IN MONTANA SURVEY

Disability	Percent of Total Identified *	Rate Per Thousand of Montana's General Population
Orthopedic	14.75%	2.20
Arthritis	6.12%	.91
Visual Impairment	9.28%	1.38
Amputations	2.06%	.30
Hearing Impairment	8.82%	1.31
Cardiac and stroke	10.97%	1.64
TB and Respiratory	4.84%	.72
Epilepsy	3.61%	.54
Speech Impairment	9.36%	1.39
Diabetes	3.64%	.54
Alcoholism	5.46%	.81
Drug Addiction	.28%	.04
Mental Illness	6.49%	.97
Mental Retardation	20.98%	3.13
Delinquency	2.99%	.44
Habitual Criminal	.22%	.03
Other	13.51%	2.02
No Response	.73%	.11

* Total percentage is over 100, due to multiple disabilities.

There was a total of 18.48 disabilities per 1,000 population reported. When adjusted for multiple disabilities on an individual case basis, there were reported 15.66 disabled individuals per 1,000 general population.

COMMENTS:

Statewide, the highest percentage of disabilities reported were mental retardation, 20.98%, and orthopedic conditions, 14.75%. Cardiac conditions, including stroke, constituted 10.97% of all disabled reported. Speech problems were 9.36%, and visual problems, 9.28% of all disabilities. No inference can be made that these figures represent an indication of incidence of conditions in the general population, as they relate only to those reported by the survey. The low percentages of individuals identified in certain categories is an inherent deficiency of any survey method, as conditions not of an obvious nature, or conditions which have a connotation of morality or prejudice, are never adequately reported. In the first category could be included cardiac respiratory conditions and diabetes; in the second, alcoholism, epilepsy, mental illness, addiction, and anti-social behavior.

On the basis of regional reporting, considerable variations as to disabilities reported are noted; generally, the variations are greater in the category of disability than in other survey categories. This can be explained on the basis of a bias of the reporting agencies toward certain conditions as much as on the basis of actual variations of disability incidence rates. Other factors involved are the awareness created by prior projects, notably the State Mental Retardation Planning group, and/or local or regional activity such as the Eastern Montana Mental Retardation Association and the concern for alcohol problems on the reservation in Region 5.

For example, Region 5 reported 29% of all surveyed as being retarded, versus 13.9% in Region 3. Region 2 reported 16.8% orthopedic, followed by Region 4 with 16.4% orthopedic. Region 1 reported the lowest number of orthopedic problems, 11.5%, despite the fact that the Region is an area of logging and other heavy employment activities.

TABLE 26

SELECTED REPORTED DISABILITIES BY REGION

Region	Mental Retardation	Orthopedic	Cardiac	Arthritis	Visual	Speech	Hearing	Alcohol	Other
1	21.0%	11.5%	11.8%	7.7%	7.2%	9.2%	5.7%	3.8%	40.9%
2	18.7%	16.8%	10.0%	6.9%	9.6%	9.9%	10.4%	6.2%	38.8%
3	13.9%	15.2%	12.0%	5.3%	8.7%	5.0%	8.4%	4.9%	48.6%
4	24.9%	16.4%	9.0%	4.4%	10.0%	11.7%	10.4%	2.8%	37.6%
5	29.0%	13.1%	12.2%	6.9%	11.2%	12.2%	9.1%	11.2%	36.0%

NOTE: Percentages in each Region total more than 100, due to multiple disabilities.

TABLE 27 - REPORTING AGENCIES - SEX REPORTED

		Region 1	Region 2	Region 3	Region 4	Region 5	TOTALS
No Response	M	3	1	0	1	1	6
	F	9	1	1	3	0	14
Welfare	M	140	259	126	232	274	1031
	F	152	184	136	238	210	920
Public Health	M	205	167	80	513	208	1173
	F	243	136	66	383	151	979
Employment Service	M	110	289	225	113	5	742
	F	25	70	69	31	4	199
School	M	303	391	695	316	255	1960
	F	227	302	431	178	167	1305
Probation & Parole	M	80	0	11	29	27	147
	F	16	0	1	13	4	34
Community Action	M	165	26	86	9	55	341
	F	88	6	60	6	29	189
County Extension	M	26	46	1	21	34	128
	F	12	25	1	7	10	55
Other	M	186	115	319	109	144	873
	F	45	93	179	58	84	459

COMMENTS:

Variations by reporting agencies were considerable, as would be expected of a voluntary survey which was dependent on a rather high degree of interest in the Project and in the disabled individual with whom it was concerned. The completion of survey forms, while requiring a minimum of time individually, did, in many instances, require a considerable expenditure of time on the part of already overworked agency personnel. That the response was so great under these circumstances is one of the most encouraging signs for the future of rehabilitation of the disabled, as it reflects an inordinate degree of interest in the needs of the disabled at the operational level.

Review of the tabulations reported above must be made with the awareness that not all agencies received questionnaires and that, because of personnel shortages in known instances, it was not possible to have forms completed by all agencies.

THE DISABLED OF MONTANA: ESTIMATES AND PROJECTIONS OF CHRONIC DISABILITY AND ACTIVITY LIMITATIONS

The estimates of chronic disabilities and activity limitations for Montana, and for the five planning regions, are derived from national rates compiled by the National Center for Health Statistics.[2] Data is collected through household interviews in the Health Interview Survey, a continuing program of the National Center for Health Statistics. Each year interviews are conducted in a sampling of approximately 42,000 households, which comprise 134,000 people. This is a sampling of the civilian non-institutional population of the United States. It does not include members of the armed services or United States Nationals living in foreign countries.

The application of national rates to particular areas introduces possible error due to difference in regional characteristics. Also, the assumption that disability rates will remain constant in projecting to future years is subject to error due to constant change in population characteristics and new treatment methods.

However, the application of national rates to Montana and its regions can be helpful in overall planning for vocational rehabilitation services and facilities.

National rates used for Montana estimates are those resulting from interviews between July, 1961 and June, 1963. Four categories were reported from these interviews: (1) with no limitation in activity; (2) with limitation but not in major activity; (3) with limitation in amount or kind of activity; and (4) unable to carry on major activity. Major activity was defined as "...the ability to work, keep house, or engage in school or preschool activities." Estimates derived for Montana and its regions are based on the two most limiting conditions since they are assumed to more closely coincide with requirements for services from the Division of Vocational Rehabilitation and related agencies.

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[2] Public Health Service, _Chronic Conditions and Activity Limitations; United States - July, 1961 - June, 1963_, United States Department of Health, Education, and Welfare.

For each disability category used, the rate per thousand of population was computed from national figures and applied to the population of Montana and the five planning areas.[3]

In some cases, the estimates of number of disabled people may be high due to persons reporting more than one disability. Conversely, only selected conditions are reported. Population projections used are Series 1D estimates of the Bureau of the Census, United States Department of Commerce, and are the most conservative projections appearing in their Series P-25, No. 326, dated February 7, 1966.

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[3] Totals in the regional figures for 1960 and 1970 do not agree exactly with the state figures, as their derivation was based on percentages in each disability category.

TABLE 28

CHRONIC CONDITIONS AND ACTIVITY LIMITATIONS IN MONTANA

	1960			1970			1975		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Tuberculosis, all forms	359	170	529	394	186	580	412	195	607
Malignant neoplasms	359	401	760	394	441	835	412	461	873
Benign and unspecified neoplasms	449	200	649	493	220	713	516	230	746
Asthma-hay fever	2,066	679	2,745	2,268	746	3,014	2,372	780	3,152
Diabetes	1,033	633	1,666	1,133	695	1,828	1,186	727	1,913
Mental and nervous conditions	3,143	1,590	4,733	3,451	1,745	5,196	3,609	1,825	5,434
Heart conditions	7,095	3,766	10,861	7,789	4,134	11,923	8,146	4,324	12,470
Hypertension without heart involvement	2,874	849	3,723	3,155	932	4,087	3,300	975	4,275
Varicose veins	1,123	247	1,370	1,232	271	1,503	1,290	284	1,574
Hemorrhoids	629	185	814	690	203	893	722	213	935
Other conditions of circulatory system	1,482	880	2,362	1,626	966	2,592	1,701	1,010	2,711
Chronic sinusitis and bronchitis	1,212	355	1,567	1,331	390	1,721	1,392	408	1,800
Other conditions of respiratory system	898	525	1,423	986	576	1,562	1,031	603	1,634
Peptic ulcer	1,078	417	1,495	1,183	457	1,640	1,237	478	1,715
Hernia	1,347	448	1,795	1,479	491	1,970	1,547	514	2,061
Other conditions of digestive system	2,066	926	2,992	2,268	1,017	3,285	2,372	1,063	3,435

TABLE 28 (Continued)

	1960			1970			1975		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Conditions of genito-urinary system	2,200	880	3,080	2,416	966	3,382	2,526	1,010	3,536
Arthritis and rheumatism	7,095	2,609	9,704	7,789	2,864	10,653	8,146	2,995	11,141
Other diseases of muscles, bones, and joints	1,662	340	2,002	1,824	373	2,197	1,907	389	2,296
Visual impairments	1,931	2,007	3,938	2,120	2,203	4,323	2,217	2,304	4,521
Hearing impairments	763	695	1,458	838	762	1,600	877	797	1,674
Paralysis, complete or partial	1,212	1,621	2,833	1,331	1,779	3,110	1,392	1,860	3,252
Impairments (except paralysis) of back or spine	3,907	602	4,509	4,289	661	4,950	4,485	691	5,176
Impairments (except paralysis and absence) of upper extremities and shoulders	808	185	993	887	203	1,090	928	213	1,141
Impairments (except paralysis and absence) of lower extremities and hips	2,694	957	3,651	2,957	1,051	4,008	3,093	1,099	4,192
TOTALS	49,485	22,167	71,652	54,323	24,332	78,655	56,816	25,448	82,264

On the basis of the foregoing estimates, then, it can be considered that 71,652 Montanans are limited in activity due to chronic conditions. Program experience has demonstrated, however, that not all persons who have functional limitations are in need of the services of the state-federal rehabilitation program. Additionally, there are those who may need services but do not desire to accept such services. The characteristics which ultimately determine whether the person will enter a rehabilitation program and derive benefit from it are contingent on a multiplicity of personal, social, and economic factors.

The systems of referral, diagnosis, evaluation, and entry into a prescribed program are all integral parts of the screening process. The success of the program following acceptance is determined by factors which include the nature and extent of disability, the clients perception and acceptance of his problems, the existence of secondary physical or mental conditions, the influence of family and peer attitudes, the economic pressures existent, the attitude and acceptance by the counselor of the client, age, education, and prior work and life experiences.

CHAPTER VI

MONTANA PLANNING PROJECT REGIONS

The information in this Chapter is provided with the hope that it will be of value and guidance in planning for the Regional development of special programs to meet the unique needs of each area, as expressed in the District meetings.

The development of programs and facilities, of benefit to the disabled on a statewide basis, should be in accord with the statewide plan. A proliferation of uncoordinated programs will result in needless duplication and waste of available resources.

The estimates of disabled by Region, as indicated in the Chronic Conditions and Activity Limitations table, are based on the data of the National Health Survey, and have the same basis as the statewide data as is projected in Chapter V.[1] The same limitations apply; however, caution should be exercised in the application and interpretation of data to small units. Regional differences, inherent in a state such as Montana, tend to accentuate the original survey limitations. Regional projections[2] are given only to 1970, as suitable county general population figures were not available beyond that time when projections were made.

In addition, a general compilation of the most significant characteristics of disabled persons, as individually identified in the Community Survey, are presented in narrative form and are derived from Table 28 in Chapter V.

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[1] Public Health Service, *Chronic Conditions and Activity Limitations: United States - July, 1961 - June, 1963*, United States Department of Health, Education, and Welfare.

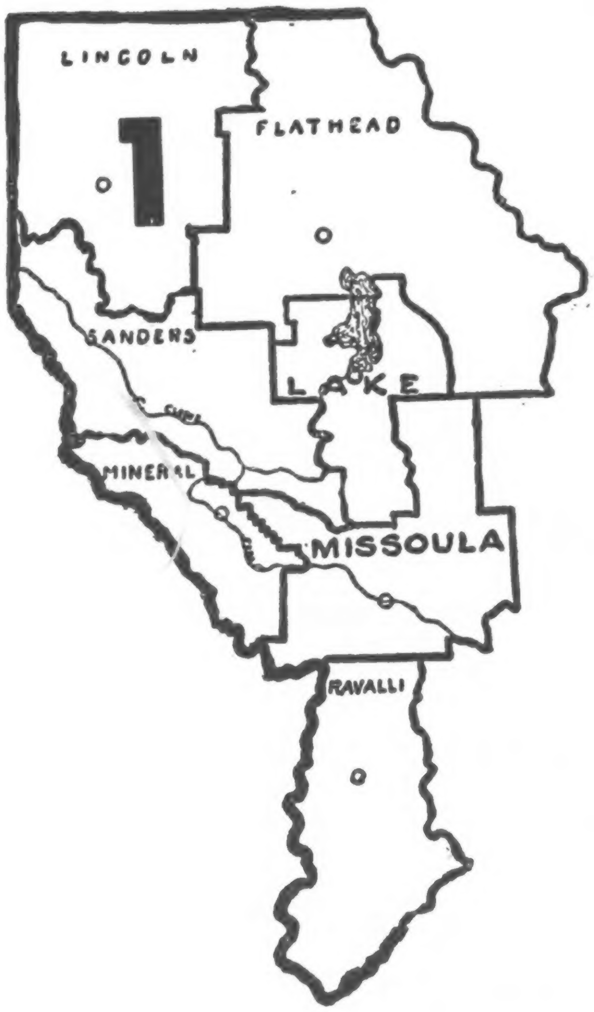
[2] Bureau of the Census, *Population Estimates*, Series P-25, No. 326, (Series 1D).

The recommendations in this Chapter are those resulting from the second meeting held within each District; they represent the need for services as expressed by the professionals and citizens of the various communities.

In recognition of the vital importance of the attitudes of the practitioners in medicine, rehabilitation, and related fields, as they bear upon the future development of rehabilitation programs, selected survey questions, responses, and respondent characteristics are presented in this section. Complete data derived from the surveys is presented in Chapter VIII.

The 102 recommendations from these sources, then, together with those of the special committees, were assimilated and developed into the statewide recommendations by the Citizens Advisory Committee. The basic Project recommendations are, therefore, preserved and presented in this manner, as it is felt that they represent the sincere and considered opinions of hundreds of individuals who have firsthand knowledge of the problems of the disabled in Montana.

Planning Region 1



Region 1 consists of Lincoln, Flathead, Lake, Sanders, Mineral, Missoula, and Ravalli Counties.

This Region contains some of the most rugged terrain in the United States. Its transportation routes run along the valleys, parallel to the mountain ranges. Route U.S. 2, in the northern part of the Region, serves east-west traffic in Lincoln and Flathead Counties. Interstate 90 serves the central portion, consisting of Missoula and Mineral Counties in east-west travel. U.S. 10A is an east-west route for Missoula and Sanders Counties. Highway 93 is the north-south route through Ravalli, Missoula, Lake and Flathead Counties. Bus service to a greater part of the area is provided in both east-west and north-south directions.

Principal industries are lumber, wood products, fruit growing, limited mining, agriculture, livestock, dairying, and manufacturing.

The principal cities are Kalispell and Missoula. Missoula is the trade center for western Montana and is the location of the University of Montana and the U.S. Forest Service Region I headquarters. It is also considered the medical center for western Montana.

Region 1 had a population of 125,527[3] in 1960, and is projected to be 144,547[4] in 1970. It contains 19,374 square miles of land area, with a population density of 6.4 persons per square mile. In 1960, there were 63,675 males and 61,852 females, with 47,398 persons under 18 years of age, and 13,453 over 65.

In 1960, the median family income was $5,230, and median education of those over 25 was 11.3 years. In April of 1968, there were 32.7 welfare recipients per thousand of population.[5] Sixteen persons per thousand were identified in the statewide survey as potential rehabilitation cases. Reported work injuries were 5 per thousand of total population in 1966-67.[6]

Region 1 has six available facilities, as utilized and designated by the Division of Vocational Rehabilitation Workshops and Facilities Project. They are all situated in Missoula:

1. Missoula Crippled Children's Treatment Center.
2. University of Montana Speech and Hearing Clinic.
3. Missoula Mental Hygiene Clinic.
4. Opportunity School.
5. University of Montana Testing and Counseling Center.
6. Missoula Child Development Center.

The Division of Vocational Rehabilitation had a total of 448 clients in this Region during the fiscal year 1967-68.

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[3] Public Health Service, Chronic...op. cit.

[4] Department of Planning and Economic Development, Montana Statistical ...op. cit.

[5] Source: Montana Department of Public Welfare.

[6] Source: Montana Industrial Accident Board.

TABLE 29. CHRONIC CONDITIONS AND ACTIVITY LIMITATIONS - REGION 1

	1960			1970		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Tuberculosis, all forms	67	32	99	77	36	113
Malignant neoplasms	67	75	142	77	86	163
Benign and unspecified neoplasms	75	37	112	96	43	139
Asthma-hay fever	384	126	510	442	145	587
Diabetes	192	117	309	220	135	355
Mental and nervous conditions	585	296	881	673	340	1,013
Heart conditions	1,320	700	2,020	1,518	806	2,324
Hypertension without heart involvement	534	160	694	615	181	796
Varicose veins	208	50	258	240	53	293
Hemorrhoids	117	34	151	134	40	174
Other conditions of circulatory system	275	163	438	317	188	505
Chronic sinusitis and bronchitis	225	66	291	259	76	335
Other conditions of respiratory system	167	97	264	192	112	304
Peptic ulcer	200	77	277	230	89	319
Hernia	250	83	333	288	95	383
Other conditions of digestive system	384	172	556	442	198	640
Conditions of genitourinary system	409	163	572	471	188	659
Arthritis and rheumatism	1,319	485	1,804	1,518	558	2,076
Other diseases of muscles, bones, and joints	309	63	372	355	72	427
Visual impairments	359	373	732	413	429	842
Hearing impairments	141	129	270	163	148	311
Paralysis, complete or partial	225	301	526	259	347	606
Impairments (except paralysis) of back or spine	726	112	838	836	128	964
Impairments (except paralysis and absence)of upper extremities and shoulders	150	34	184	173	39	212
Impairments (except paralysis and absence) of lower extremities and hips	501	178	679	576	205	781
TOTAL - ESTIMATED ALL DISABILITIES			13,312			15,321

Major Characteristics of the 2035 Disabled Identified By the Community Survey
Region 1

The survey showed that 40% of those identified as disabled were female, 59% were male, and for 1% no sex was indicated. There were 72% identified as single.

By race, 74% were Caucasian and 23% were Indian. By age, 39% were under 18, 25% were in the 21-45 age group, and 29% were over 45. In the larger categories of disability, 21% were mentally retarded, and 17% had cardiac conditions.

The agencies reporting the largest numbers were the schools, 26%, and Public Health, 22%. The work status of those reported was as follows: 39% had never worked, 32% were felt to have a definite barrier to employment, and only 5% were reported as working full-time.

Of the total number identified in the survey, 19% were from this Region.

Physicians

The Physicians Survey shows that of 157 physicians in Region 1, 86 responded to the questionnaire. By category, they were grouped as follows: 37 general practitioners, 11 surgeons, 2 pediatricians, 4 orthopedists, 3 ophthalmologists, 1 psychologist, 13 internal medicine, 8 obstetricians, 3 psychiatrists, 2 neurosurgeons, 1 dermatologist, and 1 pathologist.

These physicians were asked what additional rehabilitation services were most needed in their communities. In order of priority, they listed physical therapy as the most needed service, occupational therapy as the second most needed service, and a rehabilitation center third.

In order to find out how often they sent clients to the rehabilitation services, they were asked about referrals in the past year. Of these physicians, 41.9% had made no referrals in that period, 30.2% had referred one to three persons, 17.4% between four and six, 9.3% more than six, and 1.2% did not respond to this question.

Of the reporting physicians, 68.6% wanted to be informed by the rehabilitation agencies as to action taken in the cases they referred.

When asked to estimate the success of the rehabilitation agencies in rehabilitating their patients to a productive place in society, 7.0% felt the success was excellent, 22.1% said it was good, 11.6% said it was fair, 7.0% said it was poor, 38.4% were unable to evaluate, and 12.8% did not respond.

Physicians' opinions concerning the rehabilitation feasibility for certain special groups were as follows:

TABLE 30. PERCENTAGES OF PHYSICIANS INDICATING REHABILITATION POTENTIAL OF SPECIAL GROUPS - REGION 1

Group	Completely	Partly	Seldom	Never	Uncertain	NR
Habitual Criminal	15.1%	7.0%	10.5%	37.2%	16.3%	14.0%
Delinquent	16.3%	20.9%	39.5%	12.8%	1.2%	9.3%
Mental Retardation	16.3%	2.3%	54.7%	19.8%	3.5%	3.5%
Mental Illness	14.0%	12.8%	66.[illegible]%	3.5%	-	3.5%
Drug Addiction	12.8%	8.1%	24.4%	46.5%	5.8%	2.3%
Alcoholism	12.8%	17.4%	34.9%	31.4%	2.3%	1.2%

In giving an opinion concerning development of the rehabilitation agencies, 37.2% of the physicians said the agencies should expand services, 17.4% recommended the present status, 4.7% said services should be reduced, 23.3% had no recommendation, and 17.4% did not respond.

Nurses

In Region 1, 82 nurses responded to the survey questionnaire, which was 16.6% of the total responding statewide. Of these nurses, 67.1% were employed full-time, 25.6% part-time, and 7.3% were not employed. When questioned concerning experience, 12.2% replied that they had been employed 1 to 3 years, 7.3% from 4 to 6 years, 2.4% from 7 to 9 years, 7.3% from 10 to 12 years, and 67.1% over 12 years.

Of the respondents, 58.5% were natives of Montana.

When asked to estimate the number of patients they had worked with in the past year who could have benefited from rehabilitation services, the nurses replied as follows: 15.9% none, 34.2% between 1 and 5, 8.5% between 6 and 10, 2.4% between 10 and 20, 2.4% over 20, and 36.6% did not respond.

The nurses were asked to identify factors responsible for many disabled not receiving services: 29.6% said lack of knowledge about services, 23.5% said cost of effort necessary to get services, 13.6% said services were inadequate or not available, and 33.3% blamed apathy on the part of the client or his family.

Professionals

In Region 1, 76 educators and other professionals whose work is related to rehabilitation responded to the questionnaire. Native Montanans accounted for 58.7% of the educators and 57.7% of other professionals.

TABLE 31. EDUCATIONAL LEVEL OF RESPONDENTS
PROFESSIONAL SURVEY - REGION 1

	High School	Some College	BA	Some Graduate	MA	PHD	NR
Professional	4.8%	9.5%	38.1%	16.7%	14.3%	14.3%	2.4%
School Personnel	2.9%	-	2.9%	20.0%	68.6%	4.4%	-

This group was questioned as to the effect of disability on the work activity of their clients. By broad numerical categories, they estimated how many were out of work or restricted in work activity. Of the respondents other than educators, 17.6% reported 0-9 clients, 16.8% said 10-19 clients, 4.8% said 20-29, 4.0% said 30-39 clients, 24.4% said over 50, and 32.0% did not respond.

School personnel replied to this same question in a manner reflecting the age of their pupils: 45.7% said 0-9 of their disabled students were restricted from work, 8.7% said 50 or over, and 45.7% did not respond.

Professionals, other than school personnel, felt that many disabled were not receiving services for the following reasons: 29.1% said lack of knowledge about the service, 15.2% said cost of effort necessary to get services, 27.9% said services were inadequate or not available, and 27.9% said apathy on the part of the client or his family. School personnel responded as follows: 37.0% said lack of knowledge about the services, 7.4% said cost of effort necessary to receive services, 24.1% said services were inadequate or not available, and 31.5% said apathy on the part of the client or his family.

TABLE 32. PERCENTAGES OF PROFESSIONALS AND SCHOOL PERSONNEL MAKING REFERRALS TO DVR AND DBS - REGION 1

Division of Blind Services

	None	1-5	6-10	11-20	NR
Professional	30.8%	23.1%	3.9%	-	42.3%
School Personnel	43.5%	10.9%	-	-	45.7%
Division of Vocational Rehabilitation					
Professional	13.5%	40.4%	13.5%	11.5%	21.2%
School Personnel	23.9%	54.4%	6.5%	-	15.2%

TABLE 33. ESTIMATES OF VOCATIONAL REHABILITATION SUCCESS PROFESSIONAL SURVEY - REGION 1

	Good	Fair	Poor	Don't Know	NR
Professional	55.0%	25.0%	2.5%	12.5%	5.0%
School Personnel	47.2%	27.9%	-	27.8%	11.1%

TABLE 34. REASONS FOR NON-REFERRAL TO VOCATIONAL REHABILITATION PROFESSIONAL SURVEY - REGION 1

	Age below VR eligibility	Age over labor market	No suitable referral system	Not familiar with agency	No barriers to employment	Other	NR
Professional	45.0%	10.0%	-	-	15.0%	30.0%	-
School	50.0%	3.6%	3.6%	-	17.9%	25.0%	-

RECOMMENDATIONS - REGION 1

1. It is recommended that steps be taken to eliminate duplication of services between the Department of Public Welfare, the Employment Service, and the Division of Vocational Rehabilitation.

2. There should be increased coordination between agencies to assure that there is continuity of service to the disabled.

3. Rehabilitation services should be extended to heads of households, such as women receiving Aid to Dependent Children, who require special services but who do not qualify for services because they do not have a definable physical or mental disability.

4. An active program is necessary to increase public and employer acceptance of the disabled as potential employees and to develop placement opportunities for the disabled individual.

5. Follow-up services are essential if the disabled individual is to be retained on his job.

6. A special program should be initiated to increase the sensitivity of school personnel to the needs of severely disabled children, such as the retarded or epileptic.

7. There is a critical need for speech therapy in the schools in Mineral, Sanders, and Ravalli Counties. These services should be available at least two to three times per week for each child requiring therapy.

8. The Division of Vocational Rehabilitation should dynamically promote the development of services for the disabled in the schools and should extend services to those disabled in schools.

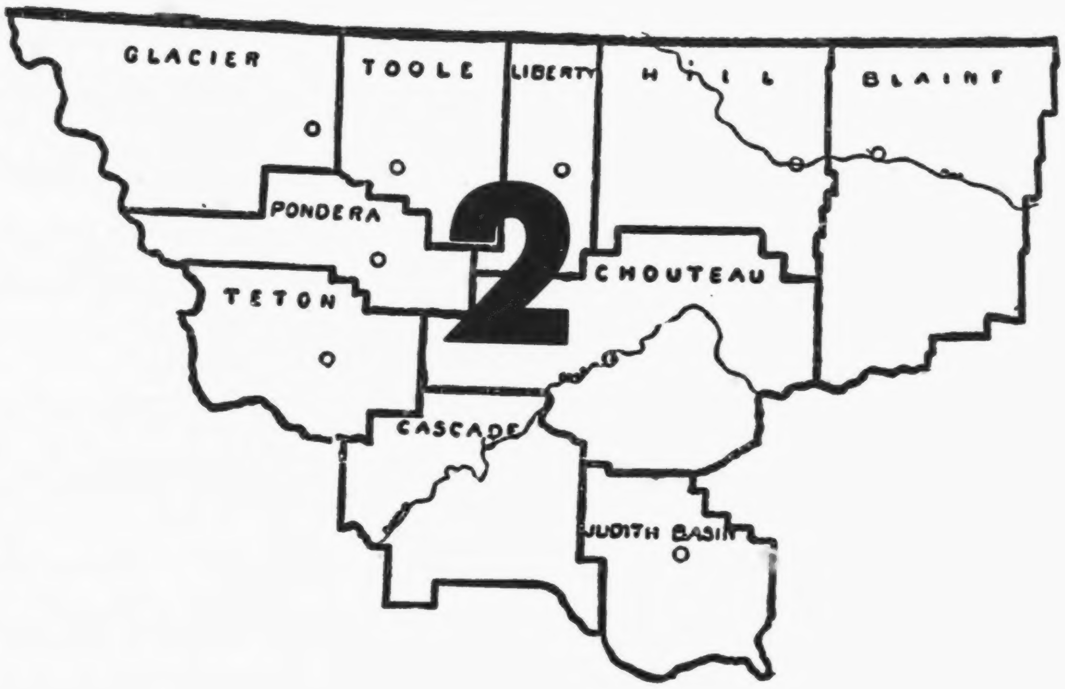
9. A Work-Study program should be developed by the Division of Vocational Rehabilitation and the school districts to serve the retarded and other exceptional children at the high school level.

10. There is a need for a well-planned and staffed workshop for the evaluation and training of the severely disabled.

11. Halfway houses should be established to facilitate the transition of institutionalized persons back into the community, and as part of these services there should be family counseling as well as individual counseling.

12. It is recommended that a Vocational Rehabilitation office be established in the Flathead area.

Planning Region 2



Region 2 consists of Glacier, Toole, Pondera, Liberty, Hill, Blaine, Teton, Chouteau, Cascade, and Judith Basin Counties.

This area is east of the Continental Divide, and is relatively flat. Travel is mostly east-west. The principal east-west highway is U.S. 2. North-south roads are U.S. highways 89, 91, 87, and 191, which is between Lewistown and Malta. There is generally good bus service in the Region.

Industries are diversified, including agriculture, livestock, smelting, flour milling, oil refining, and some manufacturing.

Rocky Boy's, Fort Belknap, and Blackfoot Indian Reservations are in Region 2.

Great Falls is the largest city in the area, and is the trade and medical center of the Region. Great Falls is the location of the College of Great Falls, Malmstrom Air Force Base, the smelter and electrolytic plant of the Anaconda Company, and near a series of dams generating power for the Montana Power Company. Havre is the second largest city in the area, and is the location of Northern Montana College.

Region 2 had a population of 145,636[7] in 1960, and is projected to be 175,798[8] in 1970. It contains 25,952 square miles of land area, with a population density of 5.7 persons per square mile. In 1960, there were 75,876 males and 71,760 females, with 57,976 persons under 18 years of age, and 11,663 over 65.

In 1960, the median family income was $5,729, and median education for those over 25 was 11.6 years. In April of 1968, there were 43.1 welfare recipients per thousand of population.[9] Fourteen people per thousand were identified as being potential rehabilitation cases in the statewide survey. Work injuries reported in 1966-67 were 2.7 per thousand of total population.[10]

Region 2 has four available facilities, as utilized and designated by the Division of Vocational Rehabilitation Workshops and Facilities Project. They are all situated in Great Falls:

1. Easter Seal Rehabilitation Center.
2. Cascade County Convalescent Hospital.
3. State School for the Deaf and Blind.
4. Montana Heart Diagnostic and Evaluation Center.

The Division of Vocational Rehabilitation had a total of 604 clients in this Region during the fiscal year 1967-68.

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[7] Public Health Service, Chronic...op. cit.

[8] Department of Planning and Economic Development, Montana Statistical ...op. cit.

[9] Source: Montana Department of Public Welfare.

[10] Source: Montana Industrial Accident Board.

TABLE 35. CHRONIC CONDITIONS AND ACTIVITY LIMITATIONS - REGION 2

	1960			1970		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Tuberculosis, all forms	78	37	115	93	44	137
Malignant neoplasms	78	84	162	93	104	197
Benign and unspecified neoplasms	98	43	141	116	52	168
Asthma-hay fever	450	148	598	537	176	713
Diabetes	225	138	363	268	164	432
Mental and nervous conditions	685	346	1,031	817	413	1,230
Heart conditions	1,546	821	2,367	1,846	979	2,825
Hypertension without heart involvement	626	185	811	747	220	967
Varicose veins	244	53	297	292	64	356
Hemorrhoids	137	40	177	163	48	211
Other conditions of circulatory system	323	191	514	385	228	613
Chronic sinusitis and bronchitis	264	77	341	315	92	407
Other conditions of respiratory system	195	114	309	233	136	369
Peptic ulcer	235	91	326	280	108	388
Hernia	293	97	390	350	116	466
Other conditions of digestive system	450	201	651	537	241	778
Conditions of genitourinary system	479	191	670	572	229	801
Arthritis and rheumatism	1,546	568	2,114	1,846	678	2,524
Other diseases of muscles, bones, and joints	362	74	436	432	88	520
Visual impairments	421	437	858	502	522	1,024
Hearing impairments	166	151	317	198	180	378
Paralysis, complete or partial	264	353	617	315	421	736
Impairments (except paralysis) of back or spine	851	131	982	1,016	156	1,172
Impairments (except paralysis and absence)of upper extremities and shoulders	176	40	216	210	48	258
Impairments (except paralysis and absence) of lower extremities and hips	587	208	795	700	249	949
TOTAL - ESTIMATED ALL DISABILITIES			15,598			18,619

Major Characteristics of the 2111 Disabled Identified By the Community Survey
Region 2

The survey showed that 38% of those identified as disabled were female, 61% were male, and for 1% no sex was indicated. There were 58% identified as single.

By race, 85% were Caucasian and 15% were Indian. By age, 25% were under 18 years of age, 23% were in the 21-45 age group, and 35% were over 46. In the larger categories of disability, 27% were mentally retarded and 22% orthopedic.

The agencies that reported the largest numbers were the schools, 47%, and Welfare, 29%. The work status of those reported was as follows: 59% had never worked, 41% were felt to have a definite barrier to employment, and only 3.3% were reported as working full-time.

Of the total number identified in the survey, 20% were from this Region.

Physicians

The Physicians Survey shows that of 147 physicians in Region 2, 66 responded to the questionnaire. By category, they were grouped as follows: 32 general practitioners, 6 surgeons, 4 pediatricians, 3 orthopedists, 6 ophthalmologists, 5 internal medicine, 7 obstetricians, 1 psychiatrist, 1 neurosurgeon, and 1 thoracic surgeon.

These physicians were asked what additional rehabilitation services were most needed in their communities. In order of priority, they listed a psychologist as the most useful service needed, a psychiatric social worker as the second most needed service, and a medical social worker as the third most needed.

In order to find out how often they sent clients to the rehabilitation services, they were asked about referrals in the past year. Of these physicians, 39.4% had made no referrals in that period, 22.7% had referred one to three persons, 16.7% between four and six, 19.7% more than six, and 1.5% did not respond.

Of the reporting physicians, 80.3% wanted to be informed by the rehabilitation agencies as to action taken in the cases they referred.

When asked to estimate the success of the rehabilitation agencies in rehabilitating their patients to a productive place in society, 6.1% felt the success was excellent, 22.7% said it was good, 9.1% said it was fair, 4.6% said it was poor, 48.5% were unable to evaluate, and 7.6% did not respond.

Physicians' opinions concerning the rehabilitation feasibility for certain special groups were as follows:

TABLE 36. PERCENTAGES OF PHYSICIANS INDICATING REHABILITATION POTENTIAL OF SPECIAL GROUPS - REGION 2

Group	Completely	Partly	Seldom	Never	Uncertain	NR
Habitual Criminal	21.2%	7.6%	13.6%	43.9%	9.1%	4.6%
Delinquent	15.2%	18.2%	47.0%	12.1%	3.0%	4.6%
Mental Retardation	15.2%	-	48.5%	28.8%	4.6%	5.9%
Mental Illness	13.6%	3.0%	66.7%	13.6%	-	3.0%
Drug Addiction	15.2%	16.7%	22.7%	36.4%	3.0%	6.1%
Alcoholism	15.2%	22.7%	24.2%	30.3%	1.5%	6.1%

In giving an opinion concerning development of the rehabilitation agencies, 43.9% of the physicians said the agencies should expand services, 18.2% recommended the present status, 1.5% said services should be reduced, 22.7% had no recommendation, and 13.6% did not respond.

Nurses

In Region 2, 119 nurses responded to the survey questionnaire, which was 24.1% of the total responding statewide. Of these nurses, 69.8% were employed full-time, 21.0% part-time, and 7.6% were not employed. When questioned concerning experience, 10.1% replied that they had been employed 1 to 3 years, 7.6% from 4 to 6 years, 9.2% from 7 to 9 years, 8.4% from 10 to 12 years, and 63.0% over 12 years.

Of the respondents, 64.7% were natives of Montana.

When asked to estimate the number of patients they had worked with in the past year who could have benefited from rehabilitation services, the nurses replied as follows: 21.9% none, 21.0% between 1 and 5, 10.9% between 6 and 10, 3.4% between 10 and 20, 4.2% over 20, and 38.7% did not respond.

The nurses were asked to identify factors responsible for many disabled not receiving services: 38.3% said lack of knowledge about services, 11.4% said cost of effort necessary to get services, 17.0% said services were inadequate or not available, and 33.3% blamed apathy on the part of the client or his family.

Professionals

In Region 2, 82 educators and other professionals whose work is related to rehabilitation responded to the questionnaire. Native Montanans accounted for 56.6% of the educators and 65.45% of the other professionals.

TABLE 37. EDUCATIONAL LEVEL OF RESPONDENTS
PROFESSIONAL SURVEY - REGION 2

	High School	Some College	BA	Some Graduate	MA	PHD	NR
Professional	-	5.4%	46.0%	27.0%	21.6%	-	-
School Personnel	-	4.9%	7.3%	24.4%	63.4%	-	-

This group was questioned as to the effect of disability on the work activity of their clients. By broad numerical categories, they estimated how many were out of work or restricted in work activity. Of the respondents other than educators 20.0% reported 0-9 clients, 29.1% said 10-19 clients, 1.8% said 20-29 clients, 3.6% said 30-39 clients, 20.0% said over 50, and 25.5% did not respond.

School personnel replied to this same question in a manner reflecting the age of their pupils: 54.7% said 0-9 of their disabled students were restricted from work, and 45.3% did not respond.

Professionals, other than school personnel, felt that many disabled were not receiving services for the following reasons: 37.2% said lack of knowledge about the services, 6.4% said cost of effort necessary to get services, 33.0% said services were inadequate or not available, and 23.4% said apathy on the part of the client or his family. School personnel responded as follows: 34.7% said lack of knowledge about the services, 4.1% said cost of effort necessary to receive services, 20.4% said services were inadequate or not available, and 40.8% said apathy on the part of the client or his family.

TABLE 38. PERCENTAGES OF PROFESSIONALS AND SCHOOL PERSONNEL MAKING REFERRALS TO DVR AND DBS - REGION 2

Division of Blind Services

	None	1-5	6-10	11-20	NR
Professional	29.1%	34.6%	-	5.5%	30.9%
School Personnel	50.9%	9.4%	-	-	39.6%
Division of Vocational Rehabilitation					
Professional	27.3%	14.6%	30.9%	14.6%	12.7%
School Personnel	37.3%	34.0%	7.6%	1.9%	18.9%

TABLE 39. ESTIMATES OF VOCATIONAL REHABILITATION SUCCESS PROFESSIONAL SURVEY - REGION 2

	Good	Fair	Poor	Don't Know	NR
Professional	46.5%	27.9%	4.7%	7.0%	14.0%
School Personnel	30.2%	27.9%	4.7%	23.3%	14.0%

TABLE 40. REASONS FOR NON-REFERRAL TO VOCATIONAL REHABILITATION PROFESSIONAL SURVEY - REGION 2

	Age below VR eligibility	Age over labor market	No suitable referral system	Not familiar with agency	No employment barriers	Other	NR
Professional	18.2%	15.2%	15.2%	9.1%	21.2%	21.2%	-
School Personnel	57.9%	-	7.9%	2.6%	7.9%	23.7%	-

RECOMMENDATIONS - REGION 2

1. It is recommended that emphasis be given to programs of early detection of disability to help prevent the development of conditions that later require rehabilitation.

2. A combined program offering services to those in the 6-17 age group, and having speech or visual impairments or emotional problems, is needed.

3. Special education classes, with a provision for boarding care, are needed for the trainable mentally retarded.

4. The emotionally disturbed child, and the adult with alcoholism and personality problems, require special services. These should be provided within a mental health center or as part of a community hospital.

5. Adequate psychological testing services are necessary to overcome the current long delays in procuring testing.

6. It is recommended that consideration be given to including in the plans of the Havre hospital the services of an orthopedic surgeon, an ophthalmologist, a psychiatrist, an occupational therapist, and a specialist in ear, nose, and throat.

7. It is necessary that a program be initiated by the Division of Vocational Rehabilitation to present information on the needs of the disabled and the fact that, properly trained, they can become effective workers.

8. In recognition of the difficulties encountered in recruitment of professional people in all fields, it is recommended that salaries be increased to a level which will allow Montana to compete with other states.

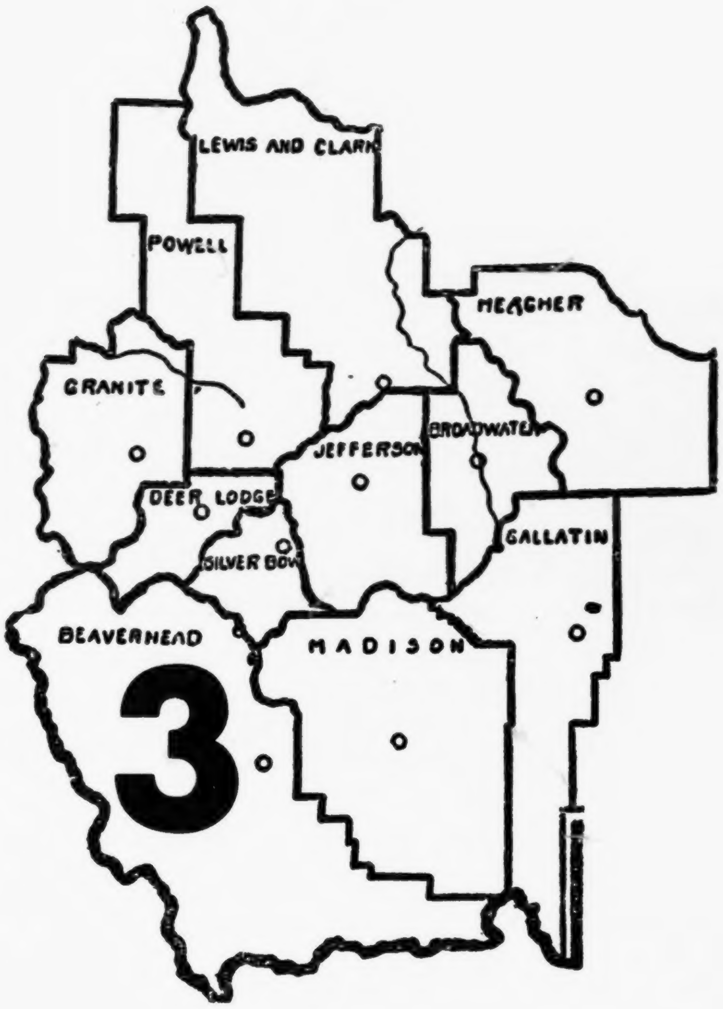
9. High standards of services and facilities must be met if the disabled are to be properly served. Coordination of planning of those groups developing programs is necessary. Consideration should be given by communities to designate one agency to coordinate services to the handicapped, and to function as a clearing house for services to the needy individual.

10. Many disabled persons require special services to return to employment. Trade school facilities should be developed for the training of the disabled, and for those who have lessened ability because of mental conditions.

11. Halfway houses to assist alcoholics, those having mental disorders, and those discharged from state institutions should be started in this Region.

12. Sheltered workshops to serve all disability categories are needed for job evaluation, work experience, training, and other supportive services necessary to enable the individual to function productively in the community.

Planning Region 3


LEWIS AND CLARK
POWELL
MEAGHER
GRANITE
JEFFERSON
BROADWATER
DEER LODGE
SILVER BOW
GALLATIN
BEAVERHEAD
MADISON
3

Region 3 consists of Lewis and Clark, Jefferson, Broadwater, Meagher, Powell, Granite, Deer Lodge, Silver Bow, Beaverhead, Madison, and Gallatin Counties.

Most of this area is east of the Continental Divide and is mountainous terrain. There are good highways between cities and towns in this area. East-west highways include Interstate 90, U.S. 12, and U.S. 287. North-south travel is by Interstate 15, U.S. 91, U.S. 287, and U.S. 10.

Industries include livestock, mining, agriculture, meat packing, smelting, oil products distribution, and some manufacturing.

The main trade centers are Butte, Helena, and Bozeman. The largest city is Butte, location of the large Anaconda Copper Mining Company operation. The Montana College of Mineral Science and Technology is located there. Helena is the second largest city in the Region. It is the location of the State Capitol and Carroll College. Montana State University is in Bozeman.

Region 3 had a population of 151,283[11] in 1960, and is projected to be 156,916[12] in 1970. It contains 25,796 square miles of land area, with a population density of 5.8 per square mile. In 1960, there were 76,889 males and 74,394 females, with 54,094 persons under 18 years of age, and 15,732 over 65.

In 1960, the median family income was $5,412, and median education of those over 25 was 11.3 years. In April of 1968, there were 24.8 welfare recipients per 1,000 people.[13]

Sixteen persons per thousand were identified as being potential rehabilitation cases in the statewide survey. Reported work injuries were 3.5 per thousand total population in 1966-67.[14]

Region 3 has seven available facilities, as utilized and designated by the Division of Vocational Rehabilitation Workshops and Facilities Project:

1. Boulder River School and Hospital (Evaluation Unit), Boulder.
2. Butte Sheltered Workshop, Butte.
3. State Department of Health Speech and Hearing Clinic, Helena.
4. Shodair Crippled Children's Hospital, Helena.
5. New Horizon Halfway House, Helena.
6. Warm Springs State Hospital, Warm Springs.
7. Alcoholic Service Center, Warm Springs.

The Division of Vocational Rehabilitation had a total of 439 clients in this Region during the fiscal year 1967-68.

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[11] Public Health Service, Chronic...op. cit.

[12] Department of Planning and Economic Development, Montana Statistical ...op. cit.

[13] Source: Montana Department of Public Welfare.

[14] Source: Montana Industrial Accident Board.

TABLE 41. CHRONIC CONDITIONS AND ACTIVITY LIMITATIONS - REGION 3

	1960			1970		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Tuberculosis, all forms	80	38	118	83	39	122
Malignant neoplasms	80	89	169	83	93	176
Benign and unspecified neoplasms	100	44	144	104	46	150
Asthma-hay fever	462	152	614	480	158	638
Diabetes	231	141	372	240	147	387
Mental and nervous conditions	704	356	1,060	731	369	1,100
Heart conditions	1,589	843	2,432	1,651	876	2,527
Hypertension without heart involvement	643	190	833	668	197	865
Varicose veins	251	55	306	261	57	318
Hemorrhoids	140	41	181	146	43	189
Other conditions of circulatory system	332	197	529	344	204	548
Chronic sinusitis and bronchitis	271	79	350	282	82	364
Other conditions of respiratory system	201	117	318	209	122	331
Peptic ulcer	241	93	334	250	96	346
Hernia	301	100	401	313	104	417
Other conditions of digestive system	462	207	669	480	215	695
Conditions of genitourinary system	492	197	689	512	204	716
Arthritis and rheumatism	1,589	584	2,173	1,651	607	2,258
Other diseases of muscles, bones, and joints	372	76	448	386	79	465
Visual impairments	432	449	881	449	467	916
Hearing impairments	171	155	326	177	161	338
Paralysis, complete or partial	271	363	634	282	377	659
Impairments (except paralysis) of back or spine	875	134	1,009	909	140	1,049
Impairments (except paralysis and absence) of upper extremities and shoulders	180	41	221	188	43	231
Impairments (except paralysis and absence) of lower extremities and hips	603	214	817	626	222	848
TOTAL - ESTIMATED ALL DISABILITIES			16,028			16,653

Major Characteristics of the 2487 Disabled Individuals
By the Community Survey
Region 3

The survey showed that 37% of those identified as disabled were female, 62% were male, and for 1% no sex was indicated. There were 65% identified as single.

By race, 95% were Caucasian and 3% were Indian. By age, 49% were under 18, 15% were in the 21-45 age group, and 28% were over 45. In the larger categories of disability, 21% were orthopedic, 17% were mentally retarded, and 16% had cardiac conditions.

The agencies reporting the largest numbers were the schools, 45%, Employment Service, 11%, and Welfare, 10%. The work status of those reported was as follows: 67% had never worked, 33% were felt to have a definite barrier to employment, and only 6% were reported as working full-time.

Of the total number identified in the survey, 24% were from this Region.

Physicians

The Physicians Survey shows that of 173 physicians in Region 3, 92 responded to the questionnaire. By category, they were grouped as follows: 44 general practitioners, 14 surgeons, 4 pediatricians, 2 orthopedists, 4 ophthalmologists, 12 internal medicine, 5 obstetricians, 4 psychiatrists, 1 public health, 1 pathologist, and 1 proctologist.

These physicians were asked what additional rehabilitation services were most needed in their communities. In order of priority, they listed a psychologist as the most needed service and a rehabilitation center as second in importance. In third place, also, was the need for a rehabilitation center.

In order to find out how often they sent clients to the rehabilitation services, they were asked about referrals in the past year. Of these physicians, 26.1% had made no referrals in that period, 23.9% had referred one to three persons, 12.6% between four and six, and 16.3% more than six. A high percentage, 21.7% did not respond to this question.

Of the reporting physicians, 85.9% wanted to be informed by the rehabilitation agencies as to action taken in the cases they referred.

When asked to estimate the success of the rehabilitation agencies in rehabilitating their patients to a productive place in society, 6.5% felt the success was excellent, 27.2% said it was good, 17.4% said it was fair, 6.5% said it was poor, 31.2% were unable to evaluate, and 10.9% did not respond.

Physicians' opinions concerning the rehabilitation feasibility for certain special groups were as follows:

TABLE 41. PERCENTAGES OF PHYSICIANS INDICATING REHABILITATION POTENTIAL OF SPECIAL GROUPS - REGION 3

Group	Completely	Partly	Seldom	Never	Uncertain	NR
Habitual Criminal	12.0%	1.1%	13.0%	53.3%	7.6%	13.0%
Delinquent	12.0%	15.2%	57.6%	6.5%	1.1%	7.6%
Mental Retardation	10.9%	-	55.4%	22.8%	3.3%	7.6%
Mental Illness	10.9%	12.0%	68.5%	2.2%	-	6.5%
Drug Addiction	10.9%	7.6%	37.0%	33.7%	4.4%	6.5%
Alcoholism	9.8%	16.3%	52.2%	18.5%	-	3.3%

In giving an opinion concerning development of the rehabilitation agencies, 51.1% of the physicians said the agencies should expand services, 3.3% recommended the present status, 5.4% said services should be reduced, 29.4% had no recommendation, and 10.9% did not respond.

Nurses

In Region 3, 140 nurses responded to the survey questionnaire, which was 28.4% of the total responding statewide. Of these nurses, 60.7% were employed full-time, 23.6% part-time, and 12.9% were unemployed. When questioned concerning experience, 7.9% replied that they had been employed 1 to 3 years, 2.9% from 4 to 6 years, 3.6% from 7 to 9 years, 10.0% from 10 to 12 years, and 72.1% over 12 years.

Of the respondents, 61.4% were natives of Montana.

When asked to estimate the number of patients they had worked with in the past year who could have benefited from rehabilitation services, the nurses replied as follows: 22.1% none, 27.1% between 1 and 5, 6.4% between 6 and 10, 3.6% between 10 and 20, 7.9% over 20, and 32.9% did not respond.

The nurses were asked to identify factors responsible for many disabled not receiving services: 32.4% said lack of knowledge about services, 17.1% said cost of effort necessary to receive services, 22.2% said services were inadequate or not available, and 28.4% blamed apathy on the part of the client or his family.

Professionals

In Region 3, 73 educators and other professionals whose work is related to rehabilitation responded to the questionnaire. Native Montanans accounted for 55.6% of the educators and 50.8% of other professionals.

TABLE 43. EDUCATIONAL LEVEL OF RESPONDENTS
PROFESSIONAL SURVEY - REGION 3

	High School	Some College	BA	Some Graduate	MA	PHD	NR
Professional	2.3%	11.6%	39.5%	23.3%	20.9%	2.3%	-
School Personnel	-	4.9%	11.1%	25.9%	55.5%	3.7%	-

This group was questioned as to the effect of disability on the work activity of their clients. By broad numerical categories, they estimated how many were out of work or restricted in work activity. Of the respondents other than educators, 15.3% reported 0-9 clients, 10.2% said 10-19 clients, 10.2% said 20-29 clients, 30.5% said over 50, and 33.9% did not respond.

School personnel replied to this same question in a manner reflecting the age of their pupils: 41.7% said 0-9 of their disabled students were restricted from work, 5.6% reported 10-19, 2.8% said 50 or over, and 50.0% did not reply.

Professionals, other than school personnel, felt that many disabled were not receiving services for the following reasons: 29.1% said lack of knowledge about the services, 10.5% said cost of effort to receive services, 30.3% said services were inadequate or not available, and 30.3% said apathy on the part of the client or his family. School personnel responded as follows: 47.9% said lack of knowledge about the services, 5.0% said cost of effort necessary to receive services, 22.5% said services were inadequate or not available, and 25.0% said apathy on the part of the client or his family.

TABLE 44. PERCENTAGES OF PROFESSIONALS AND SCHOOL PERSONNEL MAKING REFERRALS TO DVR AND DBS - REGION 3

DIVISION OF BLIND SERVICES

	None	1-5	6-10	11-20	NR
Professional	20.3%	30.5%	-	6.8%	42.4%
School Personnel	47.2%	8.3%	-	-	44.4%
DIVISION OF VOCATIONAL REHABILITATION					
Professional	18.6%	17.0%	11.9%	28.8%	23.7%
School Personnel	36.1%	38.9%	2.8%	2.8%	19.4%

TABLE 45. ESTIMATES OF VOCATIONAL REHABILITATION SUCCESS PROFESSIONAL SURVEY - REGION 3

	Good	Fair	Poor	Don't Know	NR
Professional	48.9%	24.4%	6.7%	6.7%	13.2%
School Personnel	23.1%	15.4%	3.8%	42.3%	15.3%

TABLE 46. REASONS FOR NON-REFERRAL TO VOCATIONAL REHABILITATION PROFESSIONAL SURVEY - REGION 3

	Age below VR eligibility	Age over labor market	No suitable referral system	Not familiar with agency	No barriers to employment	Other	NR
Professional	30.0%	10.0%	10.0%	20.0%	10.0%	20.0%	-
School	37.5%	-	16.7%	16.7%	20.8%	8.3%	-

RECOMMENDATIONS - REGION 3

1. There is a need for a program to identify and refer the disabled individual at the earliest possible time, preferably at the pre-school level in the case of children, for treatment and rehabilitation services.

2. It is recommended that a formal system be developed to maintain identification of disabled persons in the increasingly mobile society, in order that case work continuity can be maintained.

3. Agencies requiring similar staff and performing similar service functions should consider steps to coordinate and to pool resources to procure expensive personnel who are in short supply.

4. The Division of Vocational Rehabilitation should extend its services to those requiring them prior to age 16.

5. The full resources of the University system have not been utilized for serving the disabled in Montana. It is recommended that the University system extend its programs for this purpose.

6. It is recommended that special education classes, specifically planned to meet the needs of the emotionally disturbed child, be incorporated in school programs.

7. Adjustment programs for the school-age child, such as work-study programs, should be promoted in local schools.

8. A formal, on-going program of public information is needed, as many persons who need services are not aware of them. Those in the helping professions should be provided current information to allow better services to the disabled. The Division of Vocational Rehabilitation and the Division of Blind Services should consider such a program.

9. Current services of speech therapy should be expanded to provide service to all who need therapy, regardless of age.

10. Halfway house facilities for the habitual criminal and the mentally retarded are needed to facilitate the transition back into the community.

11. Additional mental health facilities are necessary to better meet the needs of the community.

12. A pre-parole center should be established in Montana for dischargees from Montana State Prison.

13. A sheltered workshop for the mentally retarded is needed in Helena.

14. A study should be made to modify the standard commitment procedure now required at Warm Springs State Hospital.

15. One comprehensive rehabilitation center should be constructed in a location with adequate medical facilities.

16. A treatment center offering speech therapy, audiological screening, physical and occupational therapy would benefit the disabled in this area. A concentration of these services is needed in the treatment of multiple-handicapped persons.

17. Follow-up and supportive services, including family counseling, are needed to assure maximum benefit to those discharged from Warm Springs State Hospital. Aftercare service, on the same basis as is now provided dischargees from other institutions, is recommended.

18. Public Health nurses are able to provide follow-up in the community, and should be employed in each county.

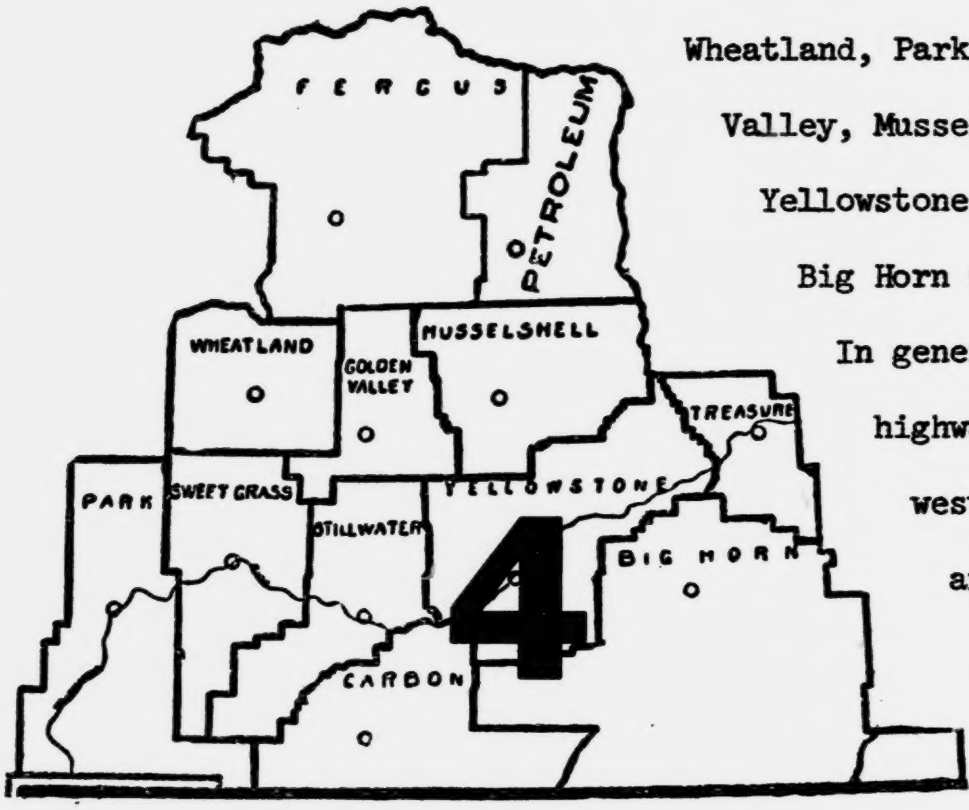
19. It is recommended that community service councils be formed, where none exist, as a means of disseminating information to professionals, that will ultimately result in better service to the disabled.

20. It is recommended that the Division of Vocational Rehabilitation establish a district office in Butte to better meet the needs of the disabled in Silver Bow, Granite, Deer Lodge, Powell, and Beaverhead Counties.

21. It is recommended that the Division of Vocational Rehabilitation and the Division of Blind Services be asked to provide sufficient counselors to provide more intensive services to the severely disabled in the district.

22. There is a great need for enforcement of legislation pertaining to architectural barriers in the construction of all new facilities, but particularly in the new vocational-technical schools.

Planning Region 4


FERGUS
PETROLEUM
WHEATLAND
GOLDEN VALLEY
MUSSELSHELL
TREASURE
PARK
SWEET GRASS
STILLWATER
YELLOWSTONE
BIG HORN
CARBON
4

Region 4 consists of Fergus, Petroleum, Wheatland, Park, Sweetgrass, Golden Valley, Musselshell, Stillwater, Yellowstone, Treasure, Carbon, and Big Horn Counties.

In general, travel is by good highways. These include east-west traffic on Interstates 90 and 94 and U.S. 12. North-south traffic is carried by U. S. routes 89, 212, 310, 87, and 91.

Industries are diversified and include agriculture, livestock, livestock marketing, meat packing, sugar refining, oil refining, trucking, mining, and some manufacturing.

Region 4 contains the Crow Indian Reservation and part of the Northern Cheyenne Reservation.

Billings is the largest city in the area, and is the trade and medical center for the Region and for northern Wyoming. It is also the home of Eastern Montana College and Rocky Mountain College.

Region 4 had a population of 144,698[15] in 1960, and is projected to be 163,169[16] in 1970. It contains 27,372 square miles of land area, with a population density of 5.3 persons per square mile. In 1960, there were 72,539 males and 72,159 females, with 56,194 persons under 18, and 14,014 over 65. In 1960, the median family income was $5,548, and median education for those over 25 was 11.5 years. In April of 1968, there were 30.7 welfare recipients per thousand of population.[17] There were 15.6 per thousand identified in the statewide survey as being potential rehabilitation cases. Reported work injuries were 2.7 per thousand of total population in 1966-67.[18]

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[15] Public Health Service, Chronic...op. cit.

[16] Department of Planning and Economic Development, Montana Statistical ...op. cit.

Region 4 has four available facilities, as utilized and designated by the Division of Vocational Rehabilitation Workshops and Facilities Project. They are all located in Billings:

1. Eastern Montana College Counseling Center.
2. Eastern Montana College Speech and Hearing Center.
3. Montana Center for Handicapped Children.
4. Handicapped Incorporated.

The Division of Vocational Rehabilitation had a total of 448 clients in this Region during the fiscal year 1967-68.

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[17] Source: Montana Department of Public Welfare.

[18] Source: Montana Industrial Accident Board.

TABLE 47. CHRONIC CONDITIONS AND ACTIVITY LIMITATIONS - REGION 4

	1960			1970		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Tuberculosis, all forms	76	36	112	86	41	127
Malignant neoplasms	76	85	161	86	97	183
Benign and unspecified neoplasms	96	42	138	108	48	156
Asthma-hay fever	442	145	587	498	164	662
Diabetes	221	135	356	249	153	402
Mental and nervous conditions	672	340	1,012	759	383	1,142
Heart conditions	1,518	805	2,323	1,713	909	2,622
Hypertension without heart involvement	615	181	796	694	205	899
Varicose veins	240	52	292	271	59	330
Hemorrhoids	134	39	173	151	44	195
Other conditions of circulatory system	317	188	505	357	212	569
Chronic sinusitis and bronchitis	259	76	335	292	85	377
Other conditions of respiratory system	192	112	304	216	126	342
Peptic ulcer	230	89	319	260	100	360
Hernia	288	95	383	325	108	433
Other conditions of digestive system	442	198	640	499	223	722
Conditions of genitourinary system	470	188	658	531	212	743
Arthritis and rheumatism	1,518	558	2,076	1,713	630	2,343
Other diseases of muscles, bones, and joints	355	72	427	401	82	483
Visual impairments	413	429	842	466	484	950
Hearing impairments	163	148	311	184	167	351
Paralysis, complete or partial	259	346	605	292	391	683
Impairments (except paralysis) of back or spine	836	128	964	943	145	1,088
Impairments (except paralysis and absence) of upper extremities and shoulders	173	39	212	195	44	239
Impairments (except paralysis and absence) of lower extremities and hips	576	204	780	650	231	881
TOTAL - ESTIMATED ALL DISABILITIES			15,311			17,282

Major Characteristics of the 2260 Disabled Identified By the Community Survey Region 4

The survey showed that 40% of those identified as disabled were female and 60% were male. There were 76% identified as single.

By race, 87% were Caucasian and 9% were Indian. By age, 63% were under 18, 13% were in the 21-45 age group, and 19% were over 45. In the larger categories of disability, 25% were mentally retarded, 16% were orthopedic, and 12% had speech impairments.

The agencies reporting the largest numbers were Public Health, 40%, schools, 22%, and Welfare, 21%. The work status of those reported was as follows: 74% had never worked, 49% were felt to have a definite barrier to employment, and only 2.5% were reported as working full-time.

Of the total number identified in the survey, 21% were from this Region.

Physicians

The Physicians Survey shows that of 151 physicians in Region 4, 85 responded to the questionnaire. By category, they were grouped as follows: 27 general practitioners, 10 surgeons, 6 pediatricians, 6 orthopedists, 10 ophthalmologists, 13 internal medicine, 4 obstetricians, 3 psychiatrists, 3 neurosurgeons, 1 dermatologist, 1 pathologist, and 1 thoracic surgeon.

These physicians were asked what additional rehabilitation services were most needed in their communities. In order of priority, they listed physical therapy as the most needed service and occupational therapy as the second most needed service. Special education classes and a treatment center were both cited as the third most needed service.

In order to find out how often they sent clients to the rehabilitation services, they were asked about referrals in the past year. Of these physicians, 37.7% had made no referrals in that period, 28.2% had referred one to three persons, 11.8% between four and six, 20.0% more than siz, and 2.4% did not respond.

Of the reporting physicians, 81.2% wanted to be informed by the rehabilitation agencies as to action taken in the cases they referred.

When asked to estimate the success of the rehabilitation agencies in rehabilitating their patients to a productive place in society, 5.9% felt the success was excellent, 22.4% said it was good, 15.3% said it was fair, 3.5% said it was poor, 41.2% were unable to evaluate, and 10.6% did not respond.

Physicians' opinions concerning the rehabilitation feasibility for certain special groups were as follows:

TABLE 48. PERCENTAGES OF PHYSICIANS INDICATING REHABILITATION POTENTIAL OF SPECIAL GROUPS - REGION 4

Group	Completely	Partly	Seldom	Never	Uncertain	NR
Habitual Criminal	15.3%	3.5%	18.8%	36.5%	17.7%	8.2%
Delinquent	15.3%	22.5%	47.7%	9.4%	-	5.9%
Mental Retardation	11.8%	-	56.5%	21.2%	4.7%	5.9%
Mental Illness	11.8%	10.6%	63.5%	7.1%	1.2%	5.9%
Drug Addiction	16.5%	11.8%	17.7%	45.9%	3.5%	4.7%
Alcoholism	12.9%	16.5%	36.5%	28.2%	3.5%	2.4%

In giving an opinion concerning development of the rehabilitation agencies, 56.5% of the physicians said the agencies should expand services, 8.2% recommended the present status, 2.4% said services should be reduced, 23.5% had no recommendation, and 9.4% did not respond.

Nurses

In Region 4, 96 nurses responded to the survey questionnaire, which was 19.5% of the total responding statewide. Of these nurses, 67.7% were employed full-time, 21.9% part-time, and 7.3% were not employed. When questioned concerning experience, 9.4% replied that they had been employed 1 to 3 years, 4.2% from 4 to 6 years, 7.3% from 7 to 9 years, 15.6% from 10 to 12 years, and 62.5% over 12 years.

Of the respondents, 53.1% were natives of Montana.

When asked to estimate the number of patients they had worked with in the past year who could have benefited from rehabilitation services, the nurses replied as follows: 21.9% none, 22.9% between 1 and 5, 10.4% between 6 and 10, 2.1% between 10 and 20, 2.1% over 20, and 40.6% did not respond.

The nurses were asked to identify factors responsible for many disabled not receiving services: 34.8% said lack of knowledge about services, 13.4% said cost of effort necessary to receive services, 22.3% said services were inadequate or not available, and 29.5% blamed apathy on the part of the client or his family.

Professionals

In Region 4, 82 educators and other professionals whose work is related to rehabilitation responded to the questionnaire. Native Montanans accounted for 56.6% of the educators and 64.7% of other professionals.

TABLE 49. EDUCATIONAL LEVEL OF RESPONDENTS
PROFESSIONAL SURVEY - REGION 4

	NA	High School	Some College	BA	Some Graduate	MA	PHD
Professional	-	-	15.8%	36.8%	18.4%	21.1%	7.9%
School Personnel	-	-	-	7.3%	31.7%	58.5%	2.4%

This group was questioned as to the effect of disability on the work activity of their clients. By broad numerical categories, they estimated how many were out of work or restricted in work activity. Of the respondents other than educators, 15.7% reported 0-9 clients, 21.6% said 10-19 clients, 3.9% said 20-29 clients, 2.0% said 30-39 clients, 25.5% said over 50, and 31.4% did not respond.

School personnel replied to this same question in a manner reflecting the age of their pupils: 45.3% said 0-9 of their disabled students were restricted from work, 5.7% said 10-19, 3.8% said over 50, and 45.3% did not respond.

Professionals, other than school personnel, felt that many disabled were not receiving services for the following reasons: 37.5% said lack of knowledge about the services, 10.4% said cost of effort necessary to receive services, 31.3% said services were inadequate or not available, and 20.8%

blamed apathy on the part of the client or his family. School personnel responded as follows: 30.6% said lack of knowledge about the services, 15.3% said cost of effort necessary to receive services, 31.9% said services were inadequate or not available, and 22.2% blamed apathy on the part of the client or his family.

TABLE 50. PERCENTAGES OF PROFESSIONALS AND SCHOOL PERSONNEL MAKING REFERRALS TO DVR AND DBS - REGION 4

DIVISION OF BLIND SERVICES

	NR	None	1-5	6-10	11-20
Professional	31.4%	35.3%	23.5%	7.8%	2.0%
School Personnel	47.2%	41.5%	11.5%	-	-
DIVISION OF VOCATIONAL REHABILITATION					
Professional	17.7%	15.7%	31.4%	13.7%	21.6%
School Personnel	11.3%	39.6%	35.9%	7.6%	5.7%

TABLE 51. ESTIMATES OF VOCATIONAL REHABILITATION SUCCESS PROFESSIONAL SURVEY - REGION 4

	Good	Fair	Poor	Don't Know	NR
Professional	48.7%	30.8%	5.1%	12.8%	2.7%
School	24.4%	19.5%	-	34.1%	22.0%

TABLE 52. REASONS FOR NON-REFERRAL TO VOCATIONAL REHABILITATION PROFESSIONAL SURVEY - REGION 4

	Age below VR eligibility	Age over labor market	No suitable referral system	Not familiar with agency	No barriers to employment	Other	NR
Professional	35.5%	3.2%	6.5%	6.5%	12.9%	35.5%	-
School	48.8%	-	9.8%	14.6%	12.2%	14.6%	-

RECOMMENDATIONS - REGION 4

1. The Department of Public Welfare, in providing medical services to disabled clients, experiences a shortage of funds for this purpose for those not qualifying for Medicaid. It is recommended that increased support of the medical care program be given.

2. In recognition of the fact that it is better to provide the disabled, needy, and indigent individual the necessary services to enable them to be self-sufficient rather than dependent, it is recommended that rehabilitation services be expanded to indigent and marginal individuals.

3. In recognition of the needs of the older arthritic individual for medical treatment, therapy, and training, it is recommended that emphasis be placed on developing programs for this group.

4. A formal program to overcome the lack of understanding and fear on the part of the public and employers regarding certain groups, such as epileptics, is necessary if rehabilitation is to occur.

5. It is recommended that services and facilities be developed for persons returning from institutions and for groups such as alcoholics. Such services would assist in the treatment and adjustment process facing persons attempting to procure and maintain employment.

6. The Department of Public Welfare is able to provide casework counseling to those persons who are on welfare rolls. This service should also be made available to those who could benefit but who are not yet eligible for categorical assistance.

7. The rehabilitative services available to other groups should be provided those aged persons who wish to remain active and productive in society. Services should also be extended to the culturally deprived and socially dependent individual.

8. There is a great need for evaluative services such as those which determine physical capabilities, work tolerance, and pre-vocational and vocational needs, in addition to psychological testing, for all disabled, but particularly disabled youth. Additional opportunities for job tryouts must be developed.

9. Services now utilized are available through various public and private agencies, and there is a need for continued coordination and cooperation in providing services and developing new services.

10. There is a need for more data regarding the capabilities of the disabled and the types of work that persons with limitations can do. It is recommended that additional research in the area of job descriptions and requirements be undertaken.

11. The person now working in the helping professions requires constant exposure to new ideas and techniques in all areas, but particularly in the area of jobs for the handicapped. In-service training would help to alleviate this need.

12. There will be increasing needs in Montana for vocational training to serve the disabled. The vocational schools must be designed to meet these needs; existing vocational training courses in fields suitable for the disabled are often of too short duration.

13. There is a need for a formal, on-going program of working with the public and the employers for development of jobs for the disabled.

14. Consideration should be given to assessing the effect of prior disability on the employer's decision to hire a disabled person. It is recognized that a second injury law exists for this purpose, but full understanding of its intent may not yet be known to all employers.

15. There is a need to prepare the disabled child for his proper productive place in society once he leaves the sheltered environs of school, through the utilization of professional services and special programs geared for this purpose.

16. There is a shortage of certain, necessary professional persons within the school system. It is recommended that school districts employ persons trained in psychology, speech therapy, audiology, and nursing to better meet the needs of the children requiring such services and to identify problems earlier so that treatment can be initiated.

17. Since the inadequacy of programs and services for diabetic children is recognized, it is recommended schools consider the development of services for this group.

18. The lack of recognition given to architectural barriers in the construction of schools is to be deplored. Steps should be instituted to remove these barriers for the full utilization of public school facilities by disabled children.

19. Additional vocational training classes must be developed with the needs of handicapped persons in mind.

20. Sheltered workshops with dormitory facilities must be developed in Montana if the vocational needs of the severely disabled are to be met.

21. Halfway houses for mentally retarded children and others who are released from state institutions are necessary if a satisfactory transition into the community is to be accomplished.

22. There is a need for a completely new reconsideration of the needs of the disabled in seeking and maintaining employment. This might include such things as providing employer incentives in hiring the disabled. Minimum wage laws present a significant problem in the administration and functioning of workshops, and a satisfactory solution to the problem must be worked out through the federal and state agencies involved.

23. Family counseling is a need in working with those with severe disabilities.

24. Rehabilitation services of all kinds must be extended to those residing in rural areas, with consideration given to mobile clinics and teams to provide certain services. Transportation of the individual to certain facilities not suitable for development in rural areas must be provided; e.g., physical therapy as a basic service is not available to those in rural areas.

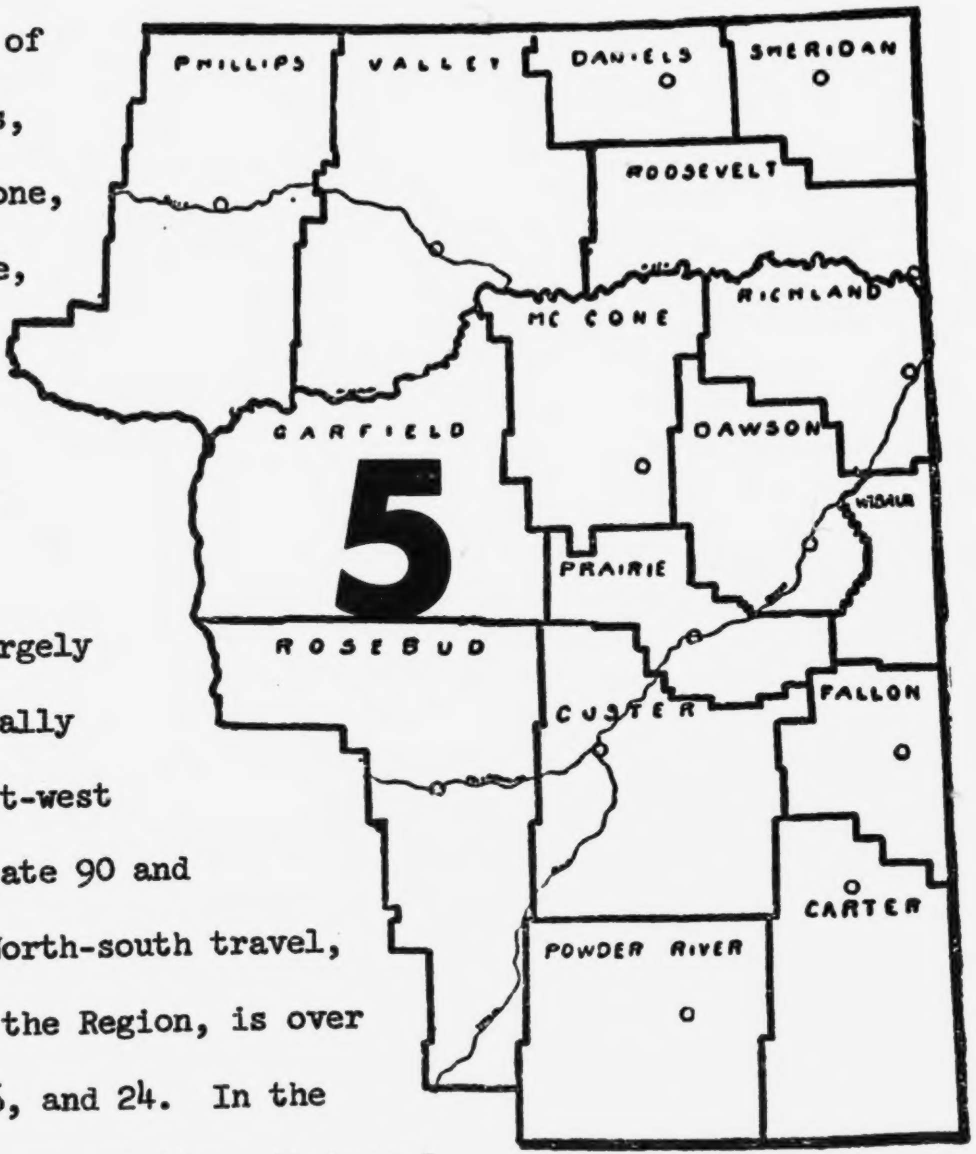
25. Rehabilitation services should be considered for age groups from infancy on up. There should be no overlapping of service from other agencies; however, there are some handicapping conditions where no services are rendered.

26. There are no services available for the mildly brain-damaged child who has difficulty with the learning process (audio or visual perception difficulties). Educational opportunities are desperately needed for these children. Those who are more severely involved should be considered for Vocational Rehabilitation as they are generally the school dropout.

27. Vocational Rehabilitation should be extended to those who are vocationally handicapped due to social circumstances. Specific groups are mothers receiving Aid to Dependent Children and juvenile delinquents.

28. A system for appeal by patients who have been turned down by their own family doctor, or for those where a weak recommendation was made, should be set up. Many patients have lost out on a satisfactory rehabilitation program for this reason.

Planning Region 5


PHILLIPS
VALLEY
DANIELS
SHERIDAN
ROOSEVELT
MC CONE
RICHLAND
GARFIELD
5
DAWSON
WIBAUX
PRAIRIE
ROSEBUD
CUSTER
FALLON
CARTER
POWDER RIVER

Region 5 consists of Phillips, Valley, Daniels, Sheridan, Roosevelt, McCone, Richland, Dawson, Prairie, Wibaux, Garfield, Rosebud, Custer, Fallon, Powder River, and Carter Counties.

This Region is largely a plains area with generally good travel routes. East-west highways include Interstate 90 and U.S. routes 2 and 12. North-south travel, in the northern part of the Region, is over State routes 247, 13, 16, and 24. In the southern part of the Region, north-south travel is over U.S. routes 212 and 312 and State routes 7 and 22. Garfield, Powder River, and Carter Counties have no common carriers.

Principal industries are agriculture, livestock, sugar beet production, sugar refining, and oil production.

Miles City, Glendive, Sidney, and Glasgow are the larger cities. Junior colleges are located at Miles City and Glendive.

Region 5 had a population of 105,576[19] in 1960, and is projected to be 104,850[20] in 1970. It contains 46,973 square miles of land area, with a population density of 2.2 persons per square mile. In 1960, there were 54,736 males and 50,840 females, with 43,340 persons under 18 years of age, and 12,086 over 65.

In 1960, the median family income was $4,804, and median education of those over 25 was 10.6 years. In April of 1968, there were 25.5 welfare recipients per thousand of population.[21] There were 15.7 persons per thousand identified in the statewide survey as potential rehabilitation cases. Reported work injuries were 1.9 per thousand of total population in 1966-67.[22]

Region 5 has no available facilities, as utilized and designated by the Division of Vocational Rehabilitation Workshops and Facilities Project. This lack is typical of the shortage of all services in this vast area. The Division of Vocational Rehabilitation had a total of 182 clients in this Region during the fiscal year 1967-68.

The services provided clients by the Division of Vocational Rehabilitation and the Division of Blind Services can be expected to show an increase, as within the past year both agencies have established field offices in Miles City. The means with which the counselors must effect rehabilitation will continue to be limited until resources and facilities, commensurate with what is available elsewhere in Montana, are developed.

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[19] Public Health Service, Chronic...op. cit.

[20] Department of Planning and Economic Development, Montana Statistical ...op. cit.

[21] Source: Montana Department of Public Welfare.

[22] Source: Montana Industrial Accident Board.

TABLE 53. CHRONIC CONDITIONS AND ACTIVITY LIMITATIONS - REGION 5

	1960			1970		
	Limited in amount or kind of major activity	Unable to carry on major activity	Total	Limited in amount or kind of major activity	Unable to carry on major activity	Total
Tuberculosis, all forms	56	26	82	55	26	81
Malignant neoplasms	56	62	118	55	62	117
Benign and unspecified neoplasms	70	31	101	69	31	100
Asthma-hay fever	322	105	427	319	105	424
Diabetes	161	98	259	159	98	257
Mental and nervous conditions	490	248	738	486	246	732
Heart conditions	1,106	587	1,693	1,098	582	1,680
Hypertension without heart involvement	448	132	580	444	131	575
Varicose veins	175	38	213	173	38	211
Hemorrhoids	98	28	126	97	28	125
Other conditions of circulatory system	231	137	368	229	136	365
Chronic sinusitis and bronchitis	189	55	244	187	55	242
Other conditions of respiratory system	140	82	222	139	81	220
Peptic ulcer	168	65	233	166	64	230
Hernia	210	70	280	208	69	277
Other conditions of digestive system	322	144	466	319	143	462
Conditions of genitourinary system	343	137	480	340	136	476
Arthritis and rheumatism	1,106	407	1,513	1,098	403	1,501
Other diseases of muscles, bones, and joints	259	53	312	257	52	309
Visual impairments	301	313	614	299	310	609
Hearing impairments	119	108	227	118	107	225
Paralysis, complete or partial	189	252	441	187	250	437
Impairments (except paralysis) of back or spine	609	94	703	604	93	697
Impairments (except paralysis and absence)of upper extremities and shoulders	126	28	154	125	28	153
Impairments (except paralysis and absence) of lower extremities and hips	420	149	569	417	148	565
TOTAL - ESTIMATED ALL DISABILITIES			11,163			11,070

Major Characteristics of the 1662 Disabled Identified
By the Community Survey
Region 5

The survey showed that 39% of those identified as disabled were female and 59% were male. There were 62% identified as single.

By race, 78% were Caucasian and 15% were Indian. By age, 39% were under 18, 23% were in the 21-45 age group, and 31% were over 45. In the larger categories of disability, 29% were mentally retarded, 13% orthopedic, 12% had cardiac conditions, and 12% had speech impairments.

The agencies reporting the largest numbers were Welfare, 29%, and the schools, 25%. The work status of those reported was as follows: 59% had never worked, 59% were felt to have a definite barrier to employment, and only 5% were reported as working full-time.

Of the total number identified in the survey, 16% were from this Region.

Physicians

The Physicians Survey shows that of 68 physicians in Region 5, 45 responded to the questionnaire. By category, they were grouped as follows: 28 general practitioners, 5 surgeons, 3 pediatricians, 3 ophthalmologists, 3 internal medicine, 2 obstetricians, and 1 psychiatrist.

These physicians were asked what additional rehabilitation services were most needed in their communities. In order of priority, they listed physical therapy as the most needed service, occupational therapy as the second most needed service, and a psychiatric social worker as the third most needed.

In order to find out how often they sent clients to the rehabilitation services, they were asked about referrals in the past year. Of these physicians, 33.3% had made no referrals in that period, 28.9% had referred one to three persons, 24.4% between four and six, and 13.3% more than six.

Of the reporting physicians, 82.2% wanted to be informed by the rehabilitation agencies as to action taken in the cases they referred.

When asked to estimate the success of the rehabilitation agencies in rehabilitating their patients to a productive place in society, 2.2% felt the success was excellent, 26.7% said it was good, 15.6% said it was fair, 6.7% said it was poor, 37.8% were unable to evaluate, and 8.9% did not respond.

Physicians' opinions concerning the rehabilitation feasibility for certain special groups were as follows:

TABLE 54. PERCENTAGES OF PHYSICIANS INDICATING REHABILITATION POTENTIAL OF SPECIAL GROUPS - REGION 5

Group	Completely	Partly	Seldom	Never	Uncertain	NR
Habitual Criminal	6.7%	4.4%	13.3%	53.3%	13.3%	8.9%
Delinquent	6.7%	28.9%	53.3%	4.4%	2.2%	4.4%
Mental Retardation	4.4%	-	68.9%	13.3%	4.4%	8.9%
Mental Illness	4.4%	2.2%	82.2%	6.7%	-	4.4%
Drug Addiction	6.7%	17.8%	31.1%	40.0%	2.2%	2.2%
Alcoholism	4.4%	17.8%	53.3%	22.2%	-	2.2%

In giving an opinion concerning development of the rehabilitation agencies, 48.9% of the physicians said the agencies should expand services, 8.9% recommended the present status, 28.9% had no recommendation, and 13.3% did not respond.

Nurses

In Region 5, 56 nurses responded to the survey questionnaire, which was 11.4% of the total responding statewide. Of these nurses, 67.9% were employed full-time, 26.8% part-time, and 5.4% were not employed. When questioned concerning experience, 7.1% replied that they had been employed 1 to 3 years, 5.4% from 4 to 6 years, 5.4% from 7 to 9 years, 1.8% from 10 to 12 years, and 80.4% over 12 years.

Of the respondents, 48.2% were natives of Montana.

When asked to estimate the number of patients they had worked with in the past year who could have benefited from rehabilitation services, the nurses replied as follows: 25.0% none, 32.1% between 1 and 5, 10.7% between 6 and 10, 8.9% over 20, and 23.2% did not respond.

The nurses were asked to identify factors responsible for many disabled not receiving services: 28.8% said lack of knowledge about services, 14.4% said cost of effort necessary to receive services, 33.1% said services were inadequate or not available, and 23.7% blamed apathy on the part of the client or his family.

Professionals

In Region 5, 51 educators and other professionals whose work is related to rehabilitation responded to the questionnaire. Native Montanans accounted for 40.0% of the educators and 60.6% of other professionals.

TABLE 55. EDUCATIONAL LEVEL OF RESPONDENTS
PROFESSIONAL SURVEY - REGION 5

	High School	Some College	BA	Some Graduate	MA	PHD	NR
Other Professional	3.8%	23.1%	34.6%	15.4%	23.1%	-	-
School Personnel	-	-	18.8%	28.1%	53.1%	-	-

This group was questioned as to the effect of disability on the work activity of their clients. By broad numerical categories, they estimated how many were out of work or restricted in work activity. Of the respondents other than educators, 24.2% reported 0-9 clients, 15.2% said 10-19 clients, 3.0% said 20-29, 12.1% said 30-39 clients, 12.1% said over 50, and 33.3% did not respond.

School personnel replied to this same question in a manner reflecting the age of their pupils: 45.0% said 0-9 of their disabled students were restricted from work, 2.5% said 10-19, 5.0% said 50 or over, and 47.5% did not respond.

Professionals, other than school personnel, felt that many disabled were not receiving services for the following reasons: 37.5% said lack of knowledge about the services, 10.4% said cost of effort necessary to get services, 31.3% said services were inadequate or not available, and 20.8% blamed apathy on the part of the client or his family.

School personnel responded as follows: 36.4% said lack of knowledge about the services, 9.1% said cost of effort necessary to receive services, 27.5% said services were inadequate or not available, and 25.0% blamed apathy on the part of the client or his family.

TABLE 56. PERCENTAGES OF PROFESSIONALS AND SCHOOL PERSONNEL MAKING REFERRALS TO DVR AND DBS - REGION 5

Division of Blind Services

	None	1-5	6-10	11-20	NR
Professional	24.2%	33.3%	3.0%	3.0%	36.4%
School Personnel	57.5%	12.5%	-	-	30.0%
Division of Vocational Rehabilitation					
Professional	21.2%	27.3%	9.1%	15.2%	27.3%
School Personnel	35.0%	45.0%	-	-	20.0%

TABLE 57. ESTIMATES OF VOCATIONAL REHABILITATION SUCCESS PROFESSIONAL SURVEY - REGION 5

	Good	Fair	Poor	Don't Know	NR
Professional	38.1%	28.8%	19.0%	4.8%	9.5%
School	20.0%	10.0%	13.3%	36.7%	20.0%

TABLE 58. REASONS FOR NON-REFERRAL TO VOCATIONAL REHABILITATION PROFESSIONAL SURVEY - REGION 5

	Age below VR eligibility	Age over labor market	No suitable referral system	Not familiar with agency	No barriers to employment	Other	NR
Professional	23.5%	5.9%	17.7%	-	11.8%	41.2%	-
School	36.1%	-	2.8%	13.9%	33.3%	13.9%	-

RECOMMENDATIONS - REGION 5

1. It is recommended that smaller Vocational Rehabilitation Districts be created to provide better service.

2. Comprehensive physical and occupational therapy is needed in this region. These services could be provided on a mobile basis in the sparsely populated areas.

3. Speech and hearing therapy should be expanded to include all areas of the state. At the present time, some communities do have this service either through the Elks Speech and Hearing Clinic or in their local schools, but there are a good many areas which are not covered. The people in these areas not covered must travel great distances to receive this type of service.

4. Education programs should be instituted for children concerning the use of alcohol and drugs, glue sniffing, smoking, gas sniffing, and similar dangerous practices.

5. Existing services in the state should be better coordinated in order to provide closer working relationships and reduce duplication of services.

6. Vocational training should be available to the mentally retarded after completion of special education classes.

7. Area trade schools are needed as an aid to vocational rehabilitation.

8. Some type of work-experience training should be implemented in the schools for the mildly retarded. Such training could be part of the special education classes.

9. There is a need for alcoholic treatment centers, set up on a halfway house basis.

10. Halfway houses should be established for dischargees of the mental institutions, dried-out alcoholics, and convicts discharged from Deer Lodge.

11. There is a need for foster home care for many of the patients discharged from Warm Springs.

12. The Division of Vocational Rehabilitation and the Division of Blind Services should have additional staff to adequately cover the large, sparsely populated areas of the state.

13. Case service monies of the vocational rehabilitation agencies should be increased in order that additional federal monies be procured for the disabled in Montana.

14. The Division of Vocational Rehabilitation and the Boulder River School and Hospital should be encouraged to continue and expand programs such as the summer program now functioning. The benefits of bringing the retarded to the School for an intensive program of adjustment and vocational evaluation are recognized.

15. The Division of Vocational Rehabilitation should be encouraged to extend services to those less than 16 years of age.

16. A broader definition of disability is needed to qualify those who need rehabilitation services but who do not have a clearly defined physical or emotional disability. Social and cultural handicaps should be included as disabling conditions.

17. Training of a vocational nature is essential for those at the Pine Hills School.

18. A trade school usable by the disabled is essential if rehabilitation is to occur.

19. Cooperative work-study programs would help to meet the vocational needs of exceptional children within the schools. Cooperative programs between groups such as the Division of Vocational Rehabilitation, the schools, and Neighborhood Youth Corps should be considered.

20. Consideration should be given to provision of the basic rehabilitation therapies to persons in rural areas. Mobile teams or other means should be considered and should include physical, speech, and occupational therapy.

21. Early detection and referral to professional services of those with disabling conditions is necessary and is to be encouraged.

22. Programs to encourage employer acceptance of the disabled as good workers are needed.

23. Many persons in this area are not aware of the services available to them, and Vocational Rehabilitation should take necessary steps to correct this situation.

24. There is a need for psychological counseling and follow-up services in the community for social and vocational adjustment for alcoholics.

25. The State Planning Commission and others who determine economic planning should encourage light industries to consider Montana for factories. The feasibility of employing well-trained, motivated persons should be prominent in such planning.

26. There is a need for the schools and the State Department of Public Instruction to provide suitable educational programs and services for the emotionally disturbed child. The programs in existence for the retarded do not meet the special needs of this group.

27. There is a need for psychiatric social workers in this District.

28. The schools should be encouraged to extend counseling through employment of trained persons, these people to work at the elementary school level.

CHAPTER VII

REHABILITATION FACILITIES

The rehabilitation of disabled persons can be accomplished through the use of many services selected to meet the particular needs of the individual. These services need not be administratively under the same agency to be effective, if they are coordinated in the individual's total rehabilitation program.

There are other services, however, which because of their complexity and nature should be provided within one physical setting or facility. Such services, while of benefit to all disabled, are absolutely essential for the rehabilitation of the severely or multiple handicapped child or adult. For the purposes of this plan a rehabilitation facility is defined as:

> ...a facility, operated for the primary purpose of assisting in the rehabilitation of handicapped individuals, (1) which provides one or more of the following types of services: testing, fitting, or training in the use of prosthetic devices; prevocational or conditioning therapy; physical or occupational therapy, adjustment training; evaluation, treatment, or control of special disabilities; or (2) through which is provided an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision, provided that the major portion of such evaluation and services is furnished within the facility, and that all medical and related health services are prescribed by, or are under the formal supervision of, persons licensed to practice medicine or surgery in the state.[1]

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[1] Title 45 - Public Welfare Act, Chapter IV, Section 401.1 (R), Vocational Rehabilitation Administration, United States Department of Health, Education, and Welfare.

This broad definition includes, then, isolated services provided by public or private agencies or individuals of a medical, treatment, therapeutic, or evaluative nature, which are available to the handicapped. These services, while essential, are outside the scope of this Chapter, but were listed in the Statewide Planning Directory of Rehabilitation Services and Facilities in Montana. Primary attention is given to those programs included in part (2) of the definition. Specific facilities of concern are:

1. Rehabilitation and Treatment centers.
2. Halfway Houses.
3. Sheltered Workshops.

A special sub-committee of the Governor's Policy Board[2] was formed jointly with the Workshop and Facilities Project of the Division of Vocational Rehabilitation to:

1. Determine what facilities, as defined above, exist in Montana.
2. Determine the adequacy of present facilities in meeting the needs of the disabled.
3. Develop recommendations for facilities to meet the needs on an interim and long-range basis.
4. Suggest methods of implementing the recommendations by public, private, or a combination of agencies.
5. Establish priorities for the development of facilities.

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[2] Refer to Appendix B.

Consultants were utilized by the committee in the areas of sheltered workshops and halfway houses. A committee of this type should be a permanent advisory committee. The development of facilities should be on a regional basis wherever appropriate. A proliferation of facilities that cannot be adequately supported must be avoided.

RECOMMENDATION 1

ALL REHABILITATION FACILITY PLANNING IN MONTANA SHOULD INCLUDE THE CONCEPT OF INTERMEDIATE FACILITIES, HEREINAFTER REFERRED TO AS THE BASE-SATELLITE SYSTEM.

COMMENTS:

The concept of a network of inter-related but autonomous facilities has been suggested as a method of overcoming the many problems that are inherent in the delivery of specialized and expensive services to a widely dispersed population. The Facilities Committee was acutely aware of the problems unique to a predominantly rural state. Further, the dearth of existing facilities offers a unique opportunity for the coordinated development of facilities, if cooperation can be elicited from the many groups, public and private, having interests in program development.

Facilities, be they rehabilitation centers or workshops, must be planned to receive the maximum benefits of the financial resources and personnel available in a particular geographic area. Patterns of transportation must be considered if those to be served are to benefit from facility programs. It is unrealistic and ultimately self-defeating for each community to independently plan and develop the specialized facilities needed by the handicapped.

The base-satellite concept then offers a method through which a large facility, well financed and staffed, would provide a comprehensive program and consultant services as an integral part of its function. The satellite units would be developed in selected outlying communities as the needs of disabled demand, and would have a formal, cooperative relationship with the base unit. It is recognized that this concept offers great promise in the area of rehabilitation in treatment centers and sheltered workshops. Selected aspects of the concept can also be applied to halfway house development. The basic unifying force would be the voluntary agreement which could delineate relationships in its various administrative and functional aspects. This type of relationship would enable the existing public and private facilities to voluntarily participate in the network on the basis of mutually accepted procedures and objectives. This would enable each organization to maintain the autonomy of its board, special projects, fund raising, and other activities. If implemented, it should reduce duplication of programs, allow sharing of specialists, and would help to insure continuity of services at a high level.

Aspects which should be included in the base-satellite concept are:

1. Complete reciprocity of referrals based on a determination of which facilities can best meet the needs of the client.
2. Representative governing board composed of members of each participating unit. This would also permit joint board orientation.

3. Exchange and utilization of staff on consultant basis, and centralized training for all staff.

4. In the case of workshops, transfer of contracts on a subcontract basis.

5. Complete organizational autonomy of local boards in policy matters, board selection, etc.

6. Agreement as to the core services to be provided at the base unit, the nature and extent of services to be provided by the satellite, subject to review and appeal, and the consideration of long-range plans to eliminate duplication.

7. Other coordinating activities as needs arise.

8. Development wherever feasible should be in accordance with the five Regions utilized by Statewide Planning, Mental Retardation, and Mental Health.

It was the unanimous opinion of the Facilities Committee that if this concept is to be effective in the coordinated development of facilities in Montana, the public agencies which will assist in funding and in providing on-going support (particularly the Division of Vocational Rehabilitation and the Division of Blind Services) will provide such support to those private and public groups which are willing to associate themselves with this concept and the overall philosophy of rehabilitation as exemplified in this report.

Rehabilitation and Treatment Centers

Rehabilitation centers were developed to provide a means of organizing treatment and services into a comprehensive and integrated program for the disabled individual. The organization and staffing patterns of centers can and do vary, and they may have a medical, vocational, or combination of orientations. A commonly accepted definition, and one used by the Conference of Rehabilitation Centers and by the United States Department of Health, Education, and Welfare follows: "A Rehabilitation Center is a facility in which there is a concentration of services, including at least one each from the medical, psycho-social, and vocational areas, which are furnished according to the need, are intensive and substantial in nature, and which are integrated with each other and with other services in the community to provide a unified evaluation and rehabilitation service to disabled people."[3]

This administrative definition does not emphasize one of the most important characteristics of a rehabilitation center, which is the manner in which the concept of rehabilitation is made an integral part of the daily operations and functions of the facility.

The perspective of staff in viewing the patient is also of considerable importance. The concept of rehabilitation that the whole person must be treated, but with recognition of individual problems and needs, must be inculcated in all staff to avoid segmentation of services within the facility.

The differentiation between rehabilitation centers and treatment centers is primarily in terms of range of services offered. Treatment centers frequently have only one or two therapies, do not have a medical director, and accept physician referrals only. They tend to be limited to orthopedic cases and are limited to out-patient care. They can, with change, develop into comprehensive centers.

Redkey in the "Planning of Rehabilitation Centers" identifies three kinds of centers - medical, vocational, and comprehensive, which offer components of both the medical and vocational. He goes on to discuss seven types of centers found in the United States, and concludes with the observation that while they can differ greatly in scope, setting, emphasis, and function, they are all rehabilitation centers, and should be developed to meet the particular needs of the disabled in each area.[4]

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[3] Redkey, H., Selected Papers, National Conference of Rehabilitation Centers, Second Annual Meeting, October, 1953, p. 10.

The existing facilities commonly considered to constitute rehabilitation or treatment centers in Montana are identified by the Workshop and Facilities Project of the Division of Vocational Rehabilitation as:

Billings - Montana Center for Handicapped Children
Helena - Shodair Crippled Children's Hospital
Great Falls - Montana Easter Seal Rehabilitation Center
Missoula - Missoula Crippled Children and Adult Rehabilitation Center

These centers are being utilized whenever possible by the Division of Vocational Rehabilitation, which also uses rehabilitation centers in other states.

Centers utilized in the past five years include:

Elks Rehabilitation Center, Boise, Idaho
Craig Rehabilitation Center, Denver, Colorado
Gottsche Rehabilitation Center, Thermopolis, Wyoming
Woodrow Wilson Rehabilitation Center, Fisherville, West Virginia
Arkansas Hot Springs Rehabilitation Center, Hot Springs, Arkansas
Minneapolis Rehabilitation Center, Minneapolis, Minnesota
Rancho Los Amigos, Downey, California
Northwest Regional Rehabilitation Center for the Blind, Seattle, Washington

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[4] Redkey, H., The Planning of Rehabilitation Centers, Papers Presented at the Institute on Rehabilitation Center Planning, February 25 - March 1, 1957, Chicago, Illinois, pp. 37-38.

Regional Rehabilitation Center, Minneapolis Society for the Blind,
Minneapolis, Minnesota
University Hospital, Seattle, Washington

RECOMMENDATION 2

A COMPREHENSIVE REHABILITATION CENTER SHOULD BE DEVELOPED IN MONTANA. IT SHOULD BE IN AN AREA WITH AN ADEQUATE MEDICAL COMMUNITY, SHOULD BE SUPPORTIVE OF TREATMENT CENTERS IN ACCORDANCE WITH THE BASE-SATELLITE CONCEPT, AND SHOULD SERVE MULTIPLE DISABILITIES, INCLUDING THOSE WHO ARE VISUALLY IMPAIRED, FROM ALL OVER THE STATE AND SURROUNDING AREAS, AND SHOULD FUNCTION IN COOPERATION WITH A UNIVERSITY.

COMMENTS:

The services of a rehabilitation center can be of benefit to many disabled who do not have access to a concentration of services. Any community or agency undertaking the development of such facilities should be cognizant of the fact that many of the patients will be those with difficult medical problems, will be poorly motivated, and will have a variety of problems which must be carefully handled. Those with lesser problems are often not candidates for such a facility, or they can be cared for more expeditiously and economically in a hospital or elsewhere.

The Vocational Rehabilitation agency, as well as other public agencies, has many clients who require the services of such a center; however, costs and other factors make it prohibitive to send all those needing such services to an out-of-state facility. A study reported that one of the largest unmet needs of vocational rehabilitation was for rehabilitation services in the psychosocial and vocational area.[5]

Services appropriately included in a comprehensive rehabilitation center program include the following:[6]

CHARACTERISTICS OF 65 REHABILITATION CENTERS

Medical (All 65 offered at least 1 medical service)	% Offering Service
Physical and medical evaluation	87.7%
Medical consultation	87.7%
Psychiatric screening	43.1%
Medical supervision	89.2%
Physical therapy	96.9%
Occupational therapy	93.8%
Speech therapy	67.7%
Audiological service	47.7%
Recreational therapy	50.8%
Psychiatric treatment	29.2%
Nursing	55.5%
Prosthetics	61.5%
Psychological (60 offered at least 1 psychological service)	
Psychological evaluation	93.8%
Personal adjustment counseling	80.0%
Group therapy	31.7%
Social (60 offered at least 1 social service)	
Social evaluation	93.3%
Social casework	88.3%
Social group work	21.7%
Recreation - non-medical	53.3%
Vocational (61 offered at least 1 vocational service)	
Vocational evaluation	90.2%
Vocational counseling	86.9%
Pre-vocational experience	78.7%
Special education	36.1%
Vocational training	37.7%
Sheltered employment	29.5%
Placement	62.3%
Travel training (blind)	8.2%

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[5] Redkey, H., *Rehabilitation Centers Today - A Report on the Operations of 77 Centers in the United States and Canada*, pp. 22-23, Office of Vocational Rehabilitation and Secretary, Conference of Rehabilitation Centers, Department of Health, Education, and Welfare.

[6] *Ibid.*, pp. 37-57.

That few centers, even those considered to be comprehensive, are able to offer all services is indicated by an in-depth study of ten in-patient and out-patient centers. All ten centers had physical therapy, speech therapy, and occupational therapy departments. Nine centers had social service departments, eight had vocational evaluation, seven had both psychological services and vocational counseling. Six centers had departments of medicine, six had workshops and all of the in-patient facilities, five, had nursing services, two provided recreation, two had vocational training, one had group work, and one had dormitory facilities.[7]

If a center in Montana offered a strong program in the major areas of services, it should prove adequate in meeting the needs of the disabled, particularly if supportive treatment centers were strategically located within each region. Treatment centers should be in-patient as well as out-patient whenever possible.

If required in the highly rural, sparsely populated areas of the state, mobile evaluative and treatment teams could operate from the treatment centers as a method of receiving referrals, making initial assessments, and providing limited treatment of a therapeutic nature in outlying areas.

Halfway Houses

Facilities that provide board and room, in a setting oriented to personal adjustment, are often required as a transitional step of the disabled person in his movement from a sheltered institutional environment to complete social and economic independence in the community. In the first category would be persons institutionalized because of mental retardation, mental illness, penal offenses, or similar reasons. The second group includes alcoholics in the community; however, a facility for this group has greater treatment orientation than that required by those in the first group who are presumed to have received treatment prior to coming to the house. The period of residence of the individual varies according to his needs and the rapidity with which he is able to be assimilated back into the community. In any event, residence should be considered temporary if the transmittal character of the facility is to be maintained.

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[7] Mott, B. J. F., Financing and Operating Rehabilitation Centers and Facilities, pp. 45-54, National Society for Crippled Children and Adults, Inc.

The concept of halfway houses in the United States is a relatively new one, and no clearly defined role or function has yet been ascribed to them, except in very general terms. Most have been established to meet the needs of a particular group such as alcoholics, mentally ill, and ex-convicts, and therefore their operation and philosophy reflects a bias toward that group. The New Horizon Halfway House in Helena is the first such facility in the state and has accomodations for 15 male alcoholics. It is currently being supported by the Division of Vocational Rehabilitation. As the program is very new, additional services are being considered.

The number of residents is generally small, approximately 15, in order to maintain a homey atmosphere. A notable exception is the 512 Fellowship in California which accomodates 500 persons in four hotels. The residents themselves contribute labor to maintain the household, and therefore the staff required is minimal. Access to professionally trained persons such as physicians, psychiatrists, psychologists, social workers, and vocational counselors is desirable to provide services of treatment, adjustment, and employment assistance to the residents.

Planning is a primary consideration as the residents are not normally able to provide their expenses initially, and only to a limited degree later as they become employed.

The active, interested support and acceptance of the community is paramount to the success of such facilities.

The goals of halfway houses, socialization and vocational adjustment of those whose disability and treatment require a slow reintegration into society, are important in successful rehabilitation. A study of Rutland Corner House, a facility for women with psychiatric problems, demonstrates the role of such facilities in rehabilitation. This facility, which has been in existence since 1877, has pioneered these transitional programs for mentally ill women and accepts predominantly those who have received a high degree of therapeutic effort. The median stay of the women studied was four months. Employment has been a major concern of the facility, so its effectiveness in that area can be assessed. Of the 48 women studied, 32 had worked at some time since leaving the house. Another basis of evaluation used was the performance of the women in the community. Thirty-five percent had been readmitted to the hospital at some time since leaving the house, but were again living in the community. Thirteen percent were in the hospital, 4% were in day hospital, and 48% had never been readmitted.[8]

The Vermont State Hospital and Vermont Vocational Rehabilitation have long sponsored halfway houses, (with considerable success), for released mental patients.

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[8] Landy, D. and Greenblatt, M., Halfway House - A Sociocultural and Clinical Study of Rutland Corner House, a Transitional Aftercare Residence for Female Psychiatric Patients, Vocational Rehabilitation Administration, United States Department of Health, Education, and Welfare.

Granville House, a transitional house for the addicted woman in St. Paul, works with both alcoholic and drug-addicted women through a program of post-treatment support.

Halfway house programs for parolees are being operated by the states of Michigan, New York, New Jersey, Oregon, Washington, Maine, Kansas, Vermont, the District of Columbia, and Puerto Rico. Other states, such as California and Illinois, use state funds to subsidize private agencies who operate halfway houses.

Because of the origins of most houses by single disability groups, most are of that nature. However, the distinction becomes clouded when it is found that individuals with but a single disability are not at all common. Multiple disability has been reported frequently in rehabilitation. Despite disagreement over the efficiency of mixing disability types, substantiation of the success of both approaches has been reported. It may be that the status of the individual in the treatment program has greater relevance than the disability evidenced.

The Colorado Division of Vocational Rehabilitation has had a program since 1948, notable in its success for serving mixed disabilities and returning them to employment. The George Williams House in St. Louis, sponsored by the YMCA, mixed delinquents, probationers, and parolees with young people who simply had no place to live while completing their educations, with apparent good results. It is somewhat incongruous that while halfway houses are a means of establishing contact and integration with the community and its realities, that within its own confines segregation in terms of disability should occur.

RECOMMENDATION 3

IT IS RECOMMENDED THAT HALFWAY HOUSE FACILITIES BE DEVELOPED IN THE COMMUNITIES OF MONTANA FOR THOSE RELEASED FROM THE INSTITUTIONS WITH DISABILITIES OF MENTAL ILLNESS, PUBLIC OFFENSES, MENTAL RETARDATION, AND ALCOHOLISM. TO DETERMINE THE FEASIBILITY OF FACILITIES SERVING MORE THAN ONE DISABILITY GROUP, IT IS RECOMMENDED THAT A JOINT DEMONSTRATION PROJECT BE UNDERTAKEN BY THE DIVISION OF VOCATIONAL REHABILITATION AND A PRIVATE AGENCY FOR THIS PURPOSE.

COMMENTS:

A great deal of disagreement is obvious in the field regarding multi versus single disability facilities. It is also recognized that it is better to develop and support adequate facilities, rather than have many ill-planned and ill-managed enterprises die from lack of community support.

Multi-disability facilities have been demonstrated to offer advantages in other facilities of a rehabilitative nature. A determination should be made regarding this in relation to halfway houses.

RECOMMENDATION 4

IT IS RECOMMENDED THAT COORDINATION BETWEEN GROUPS INTERESTED IN DIFFERENT DISABILITIES BE ENCOURAGED FOR THE PURPOSE OF DELINEATING AREAS OF RESPONSIBILITY AND TO PROMOTE THE SHARING OF STAFF, IF FEASIBLE.

COMMENTS:

The large number of disability groups able to benefit from halfway house facilities could, if coordination and cooperation is not now exercised, result in the establishment in certain communities of several single disability houses. Consideration must be given first to the disabled and his needs, but with the realization that of all facilities, halfway houses by their very nature are dependent upon community understanding and support.

Sheltered Workshops

"Since World War II, the sheltered workshop has emerged as a strong and unique element in the rapidly expanding network of specialized rehabilitation services. There has been a slow but steady movement away from the early concept of the workshop as a custodial care institution and a recognition that the proper workshop objective is the preparation of disabled individuals for competitive employment and a regular earned wage."[9] A definition of a workshop, adopted by the National Association of Sheltered Workshops and Homebound Programs, is as follows: "A sheltered workshop is a work-oriented rehabilitation facility, with a controlled working environment and individual vocational goals, which utilizes work experience and related services for assisting the handicapped person to progress toward normal living and a productive vocational status."[10]

A further distinction can be made when discussing workshop function. The transitional workshop, and the terminal or extended employment facility, each have a place in any comprehensive rehabilitation service. Each has been developed to facilitate two general groups of disabled: those capable of benefiting from intensive training and who ultimately will be placed in competitive employment in the community, and those who benefit from the workshop experience but who, because of other factors, cannot be expected to compete in the labor market. Workshops accomodating both types of client are becoming widespread.

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[9] National Association of Sheltered Workshops and Homebound Programs, _Sheltered Workshops_ - a Handbook, p. 1.

[10] _Ibid_.

The primary purpose of workshops being the preparation of the individual for employment through the provision of work related experiences and training, it becomes mandatory that the emphasis be to that end and not that of a school, hospital, rehabilitation center, or activity center.

As in the planning and development of any facility, many crucial factors must be assessed prior to program development. Paramount considerations with regard to workshops are the assessment of need for the facility within a community, and selection of a strong, representative board. A determination of the nature of the community, as it is related to the facility in terms of support, is the availability of employment for those placed from the shop. The type of suitable work that can be procured from the community, and also the type of training and the nature of supportive services, must all be decided. It must be accepted early in the planning that while the workshop will adhere to sound business practices, it is committed to serving severely disabled people. A reasonable subsidy or deficit should be looked upon as the legitimate cost to the community for a service it has decided to provide for the handicapped members of its population.[11]

Sheltered workshops can provide substantial benefits to many people disabled by all conditions. In the case of the cardiac patient, it is useful to observe work potential, measure tolerance, and to provide placement assistance in the community in an appropriate work setting. The aged population is increasingly the beneficiary of such programs. The blind, for whom the first workshop was formed in the 19th century, derive considerable assistance from workshops. A study of 132 workshops was reported by Suazo. These workshops, numbering 13,197 clients, served the following general disabilities: physical disabilities (exclusive of visually impaired) 42%, mentally retarded 21%, emotionally disturbed 13%, disabled aged 10%, visually handicapped 8%, and socially handicapped 6%. When it is realized that the vocational rehabilitation agencies constitute the largest single referral source of the workshops studied, 34%, it becomes apparent that workshops are a significant tool in the rehabilitation of the severely disabled.[12]

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[11] Ibid., p. 10.

Existing facilities that are considered to be workshops are located in only two cities in Montana, and neither offers the range of services required to adequately meet the needs of the disabled. Montana desperately requires at least one workshop offering complete vocational evaluation services to the disabled.

The two existing Montana facilities are:

Butte
    Butte Sheltered Workshop

Billings
    Handicapped, Inc.

Out-of-state workshops utilized by Vocational Rehabilitation and the Division of Blind Services include:

Goodwill Industries, Spokane, Tacoma, and Denver

Laradon Hall, Denver

Opportunity Workshop, Minneapolis

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[12] Suazo, A.C., "Sheltered Workshops and Planning," Estimating Rehabilitation Needs - A Conference on Planning for Vocational Rehabilitation, pp. 97-100.

RECOMMENDATION 5

MONTANA MUST DEVELOP MULTI-DISABILITY WORKSHOPS ON THE BASE SATELLITE CONCEPT AND THE FACILITIES SHOULD BE SO SITUATED AS TO BE READILY ACCESSIBLE TO THE DISABLED IN THE STATE. STANDARDS OF PROGRAMS SHOULD CONFORM WITH THOSE SUGGESTED BY THE NATIONAL INSTITUTE ON WORKSHOP STANDARDS AS SET FORTH IN THE HANDBOOK OF THE NATIONAL ASSOCIATION OF SHELTERED WORKSHOPS AND HOME-BOUND PROGRAMS.

COMMENTS:

The Workshop and Facilities Committee, and the consultants utilized by the Committee, were unanimous in agreeing that in Montana it would be unwise and ultimately of little real value to the disabled if spontaneous and independent development of such facilities occur in the state. Workshops must be developed on a sound basis if the workshop movement is to be advanced in the state. The industrial base of the state, the funds available, the sparse population, and the lack of trained staff all bespeak the necessity of coordinated development on the basis of multi-disability facilities.

That the multi-disability approach has greater advantages than single disability facilities has been established positively. A special project substantiated what has been empirically demonstrated by many workshops. Conclusions of the project included: (a) that the severely disabled and mentally handicapped are not fundamentally different from other individuals, and that such individuals with suitable training can become employable, and (b) the mentally retarded, emotionally disturbed, and the physically handicapped can work side by side.[13]

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[13] Opportunity Center, Inc., Occupational Adjustment Center for Persons With Mental Retardation, Emotional, and Other Physical Disabilities, Wilmington, Delaware.

Kenneth Pohlman offers several advantages in a multiple disability approach which has particular relevancy for Montana. The multiple disability shop as compared to the single disability facility draws upon a larger population, has an opportunity for greater social service, and promotes a greater desire for higher level services as a result.[14] Wilkerson agrees with this and further states that a single disability workshop is not feasible except in the largest cities; even then it is probably not desirable because the objective is to provide the widest possible variety of work and service opportunities.[15]

The base-satellite concept applied to workshops being considered in Minnesota on a regional basis[16] seems to offer advantages when applied to Montana.

The following guidelines are suggested by the Facilities Committee of Vocational Rehabilitation and the Division of Blind Services in determining where base workshops should be situated:

1. A network of rehabilitation facilities should be established to serve all types of vocationally handicapped citizens in Montana.
2. This network should be patterned on a base-satellite concept, and it should be developed to serve multiple disabilities.
3. Communities interested as a base should indicate their ability to meet the following criteria:
    a. Concentration of population.

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[14] Pohlman, K., Rehabilitation in Cardiac Disease, pp. 87-88, Research Conference, Tufts University School of Medicine, November, 1967.

[15] Wilkerson, A. M., "The Sheltered Workshop Movement - Management or Muddlement?", Journal of Rehabilitation, 31:2:20-22, March-April.

[16] Healy, M., Plan for Meeting the Long Term Sheltered Employment Needs of the Mentally Retarded of Minnesota, Unpublished Report, April, 1965.

b. Concentration of industry and business.

c. Agencies available for providing supportive services.

d. Presence of a Division of Vocational Rehabilitation office (active or planned).

e. Transportation and communication facilities.

f. Available housing.

CHAPTER VIII

PROJECT STUDIES

Preface

Understanding and acceptance of the rehabilitation programs of the Division of Vocational Rehabilitation and the Division of Blind Services by physicians, health personnel, educators, social workers, and related rehabilitation practitioners is essential if maximum utilization of available programs is to occur. The attitudes and awareness of those who work with the disabled give an excellent indication of current and future utilization patterns of the many services offered by all the public and private rehabilitation programs. They also provide information to develop professional and public information programs needed to strengthen services, and offer direction to the future development of professional services and facilities.

To this end, a survey was conducted of physicians, registered nurses, school counselors and administrators, audiologists, probation officers, employment counselors, occupational therapists, physical therapists, speech therapists, psychologists, rehabilitation counselors, social workers, and special education teachers.

An examination, of disabled individuals not successfully rehabilitated, through the study of case records, was considered advisable to determine characteristics of non-rehabilitants with the hope that program deficiencies could be corrected. A study of Division of Vocational Rehabilitation cases closed as non-rehabilitated in the prior fiscal year was therefore conducted in January and February of 1968. Only cases of the Division of Vocational Rehabilitation were studied since the number of these cases was felt sufficient to give an indication of general problem areas.

Physicians Survey

The Physicians Survey was developed by the Project staff, in cooperation with the Sociology Department of Montana State University at Bozeman and was pre-tested on ten physicians prior to mailing to all physicians licensed to practice medicine in Montana. The list utilized was that of the State Board of Health and included 731 physicians licensed as of August, 1967. Each questionnaire was accompanied by a letter signed by the physician representing the Montana Medical Association on the Project Policy Board, and included a stamped, self-addressed envelope. One follow-up mailing was made to non-respondents to the first mailing. Preliminary to this survey, official sanction of the project was received through the House of Delegates of the Montana Medical Association, upon the report and request of Dr. John W. Strizich.[1]

It was ascertained that 35 of the 731 physicians had moved or no longer resided in Montana, leaving 696 who actually received the questionnaire. There were 431 of the 696 remaining physicians, or 61.92% of all physicians licensed and practicing within the state, who responded to the survey.

Of the 431 respondents, tabulations were made on only 374 for the following reasons: certain specialities were eliminated, as they have no direct referral relationship to the Division of Vocational Rehabilitation, on the basis of past experience; specialities eliminated were urologists (7), radiologists (6), and anesthesiologists (7); 37 questionnaires were incomplete to the degree that tabulation was not feasible.

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[1] See Appendix C.

A differentiation was made on the basis of responses from specialists and general practitioners, and this distinction is alluded to in the comments. There were 44.9% of the respondents who were general practitioners, and 56.1% who were specialists.

Of the specialists group, 12.3% were surgeons, 5.1% were pediatricians, 4.0% were orthopedists, 7.0% were ophthalmologists, 12.3% were in internal medicine, 7.0% were obstetricians and gynecologists, 3.2% were psychiatrists, 1.6% were neurosurgeons, 0.3% were Public Health physicians, 0.5% were thoracic surgeons, 0.5% were dermatologists, 0.8% were pathologists, and 0.3% were proctologists.

The tabulated information is presented on the basis of number of responses received within the five Project Regions, as well as by statewide totals.

TABLE 59 - PHYSICIANS RESPONSE

REGION	Total Number in Practice	Number of Respondents	Percent of Total Respondents	Number in Private Practice Responding	Percent in Private Practice	Number in Non-Private	Percent in Non-Private
1	157	86	54.7%	83	96.5%	3	3.5%
2	147	66	44.9%	55	83.3%	11	16.6%
3	173	92	53.1%	78	84.8%	14	15.2%
4	151	85	56.3%	81	95.3%	4	4.7%
5	68	45	66.1%	36	80.0%	9	20.0%
TOTAL	696	374	53.7%	333	89.0%	41	11.0%

It might be noted that on the basis of the total number of 696 physicians, actually receiving the questionnaire and known to be residing in the Regions indicated, the response to the questionnaire was quite uniform. Region 5 is one exception and shows that a substantially larger percentage of the physicians in that area responded. On the basis of 1960 census figures, the ratio of general population to physicians by Region is as follows:

Region 1 - 799 to 1
Region 2 - 1004 to 1
Region 3 - 874 to 1
Region 4 - 958 to 1
Region 5 - 1552 to 1

This has meaning when the disproportionately larger geographic area of Region 5 is considered. It could be assumed that the larger percentage responding from that Region is some indication of physician awareness of substantial service deficiencies, and reflects their interest in stimulating needed programs. Another possible factor is that 20.5% of the respondents were in non-private employment, and this group may be more responsive to a survey of this type. The disparity of other rehabilitation personnel to the population needing services is a general condition in Region 5 and poses great problems in all rehabilitation efforts in that large Region.

The largest single type of non-private practice statewide is in federal employment, which constituted 54.1% of the total of 41 physicians in that category. Physicians employed by the state accounted for 24.3% and physicians employed by the city and county governments comprised 21.6%.

TABLE 59-A

A. How many physical, emotional, or socially handicapped patients have you referred to the Division of Blind Services or Vocational Rehabilitation in the last year? (Number of respondents, indicated by Region.)

B. What is your estimate of the success of these agencies in rehabilitating your patients back into the productive segment of society?

			REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
A	None		36	26	24	32	15	133
	1-3		26	15	22	34	13	100
	4-6		15	11	11	10	11	58
	6+		8	13	15	17	6	59
	No Response		1	1	20	2	0	24
B	Excellent	#	6	4	6	5	1	22
		%	7.0%	6.1%	6.5%	5.9%	2.2%	5.9%
	Good	#	19	15	25	19	12	90
		%	22.1%	22.7%	27.2%	22.4%	26.7%	24.1%
	Fair	#	10	6	16	13	7	52
		%	11.6%	9.1%	17.4%	15.3%	15.6%	13.9%
	Poor	#	6	3	6	3	3	21
		%	7.0%	4.6%	6.5%	3.5%	6.7%	5.6%
	Unable to Evaluate	#	33	32	29	35	17	146
		%	38.4%	48.5%	31.2%	41.2%	37.8%	39.0%
	Other	#	1	1	0	1	1	4
		%	1.2%	1.5%	0.0%	1.8%	2.2%	1.1%
	No Resp.	#	11	5	10	9	4	39
		%	12.8%	7.6%	10.9%	10.6%	8.9%	10.4%

Considering Montana as a whole, 42.0% of the responding physicians made no referrals or made no response to Question A. One to three referrals were made by 26.7%, four to six referrals were made by 15.5%, and 15.8% made more than six referrals. Apparently, over one-third of the respondents have had very little contact with the vocational rehabilitation agencies. This characteristic seemed to be more prominent in the specialist category and also in the less populous Regions, especially Region 5. Region 5 has experienced a dearth of services in the past, including those of the DVR and DBS.

Concerning Question B, all Regions, and the state as a whole, had a considerably larger percentage of the respondents represented in the "unable to evaluate" category than in any one of the other categories. This demonstrates a lack of contact and communication between physicians and the rehabilitation agencies. This condition would seem to make it incumbent upon the agencies to pursue a program which will enable the physician to more adequately assess and utilize the services offered.

Statewide, 5.9% of the respondents reported excellent success, 24.1% reported good, and 5.6% said that results were poor.

Additional analysis of responses indicates that specialists generally are less familiar with vocational rehabilitation than are the general practitioners.

TABLE 59-B

C. When one of your patients is referred to the Division of Blind Services or the Division of Vocational Rehabilitation (either by yourself or someone else), you as their doctor are asked to fill out a medical form relating to the nature of the handicap. (Not to be confused with Social Security Disability Determination form SSA-826).

1. Have you completed any of these forms in the last two (2) years?
2. If the answer to the above was "yes," do you feel the fee you received was:
3. Would you like to have the Agency inform you of their action in each individual case?
4. Are you aware that your professional opinion is the major determinate in the actinn taken by the Division of Vocational Rehabilitaion?

		REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
C-1	Yes	56	43	55	54	29	237
	No	24	20	32	28	14	118
	No Response	6	3	5	3	2	19
C-2	Adequate	41	30	39	38	19	167
	Inadequate	8	4	6	3	4	25
	Other	3	4	2	7	0	16
	No Response	34	28	45	37	22	166
C-3	Yes	59	53	79	69	37	297
	No	8	4	0	5	1	18
	Uncertain	4	2	4	3	2	15
	No Response	15	7	9	8	5	44
C-4	Yes	36	28	45	36	25	170
	No	36	30	38	41	14	159
	No Response	14	8	9	8	6	45

In response to Question C-1, twice as many of the physicians who responded to this question had completed one or more medical forms for Vocational Rehabilitation or the Division of Blind Services as had not. General practitioners replying in the affirmative exceeded by about 10.0% the number of specialists who did, which would be as expected.

Question C-2 indicates approximately an equal number who feel fees are adequate as compared to those who chose not to respond to this question. There were few comments on this question. Typical comments were "inadequate - in some instances," "would prefer to make usual and customary charge for services," "the fee for a specialist report should be as stated in M.M.A. average fee schedule," and "fee should be left to doctor's discretion." The comments indicate that not all physicians are aware that the M.M.A. fee schedule is followed by the agencies.

The response to Question C-3 is evidence that the overwhelming majority of physicians would like to be informed of the action taken on the cases with which they have been associated. The comment section did not reveal any suggestions as to a method that would prove satisfactory and practical so that this can be accomplished. The dilemma posed by this question must be satisfactorily resolved, and the current agency practices which are utilized to notify individuals and agencies of case disposition and progress should be re-evaluated. Obviously, physicians and others are less likely to utilize a program for their patients if little "feed back" and communication exists. The burden to resolve questions such as this, which are basic to assisting the needy disabled, rests with both groups, with the initiative to effect the necessary first steps being with the agency.

Question C-4 tends to indicate a large degree of uncertainty exists as to the role the physician plays in the Vocational Rehabilitation process. The agency should initiate a program that clarifies this relationship. The physician examines the client to determine the existence and nature of a physical or mental condition. This information is then evaluated by the counselor and reviewed by the Medical Consultant of the agency to determine if the condition and related factors impose functional limitations of a vocational nature.

TABLE 59-C

D. How many physically handicapped patients do you have that might benefit from service of a rehabilitative nature (who are not presently and have never been in contact with these agencies)? Please indicate the number in each diagnostic area. (Number of disabled identified).

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
Orthopedic	78	59	90	68	48	343
Arthritis	61	63	91	66	44	325
Visual Impairments	24	41	47	38	37	187
Amputations	15	14	23	11	10	73
Hearing Impairments	23	61	47	24	49	204
Cardiac, Heart & Stroke	57	51	86	60	54	308
TB & Other Respiratory	46	32	42	22	23	165
Epilepsy	22	34	43	29	30	158
Speech Impairments	17	38	36	31	34	156
Diabetes	22	20	40	23	45	150
Other	13	12	9	10	22	66

This question was included with the full recognition that it would result in an extremely gross indication of physician awareness of patient needs for rehabilitation. The response would be limited to those patients the physician could recall at the time of completing the survey, and would further be limited by the qualification that these persons have not (to the physician's knowledge) been in contact with DVR or DBS. The difficult task imposed on the physician is reflected in the large number (75.0%) of physicians who did not respond. Analysis showed further that 83.0% of the specialists and 65.5% of the general practitioners did not answer. The response of the general practitioners is significantly greater and may indicate they see more needs in general for related services than do the specialists.

Despite these limitations, it is interesting to note that 2,135 persons in ten broad categories were estimated able to benefit by the 108 physicians who responded to the question.

TABLE 59-D

E. Which of the following services of a rehabilitative nature are not available in your community?

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
Physical Therapist	12	10	11	18	24	75
Speech Therapist	19	12	24	11	23	89
Audiology	16	15	20	13	19	83
Occupational Therapist	31	23	40	29	37	160
Psychologist	30	22	33	27	33	145
Psychiatric Social Worker	33	24	33	30	39	159
Medical Social Worker	20	21	22	17	31	111
Vocational Evaluation	21	19	26	24	27	117
Special Ed. Teachers	25	15	25	23	26	114
Workshops	44	28	48	33	38	191
Halfway House	50	33	57	41	42	223
Rehab. Center	44	21	60	39	41	205
Treatment Center	40	22	48	38	37	185

This question was included to provide an inventory of rehabilitation resources available in the communities. It reveals a considerable deficiency in services which are basic and essential to comprehensive rehabilitation. Stated in percentages, we find that statewide, 20.0% of the respondent physicians do not have physical therapy services within their communities, and hence, it can be assumed, readily accessible to patients who may need this basic service. In Region 5, 53.3% of the physicians do not have such services available. The same situation was reported by 24.0% of the physicians in regard to speech therapy and audiology. Occupational therapy was reported as a community rehabilitation service unavailable by 42.8%, psychology 38.8%, psychiatric social work 42.5%, medical social work 29.7%, vocational evaluation 31.2%, and special education 30.5%.

Facilities such as sheltered workshops, halfway houses, and rehabilitation and treatment centers were indicated as being not available by approximately 50.0% of the respondents.

TABLE 59-E

F. Do you have any patients with emotional or social handicaps who might be more productive members of society if the above services as indicated in Question E, were made available to them? If "yes," how many?

G. Do you feel that the Vocational Rehabilitation Agency in Montana should: (1) Expand its services (operation); (2) Maintain the status quo; (3) Reduce its services (operation); (4) No recommendation.

		REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
F	Yes	32	34	50	43	30	189
	No	23	14	22	23	8	90
	How Many	44	61	63	64	51	283
G	Expand	32	29	47	48	22	178
	Maintain	15	12	3	7	4	41
	Reduce	4	1	5	2	0	12
	No Recommendations	20	15	27	20	13	95
	No Response	15	9	10	8	6	48

The broadened definition of disability which includes social, emotional, and other conditions will have a substantial impact on program development in the coming years. An indication of physician identification and awareness of individuals having these problems, and their ability to benefit from services, was considered to be worthwhile, as was an assessment of the attitudes of the medical community toward the rehabilitation potential of this group.

Of the physicians, 189 indicated they have such patients, 90 indicated they did not. Of the physicians who stated they had such persons as patients, 283 persons, or an average of 1.5 such patients per physician were estimated. Of the total sample of physicians then, 50.5% felt that rehabilitative services would be beneficial to the emotionally or socially handicapped person, but the number that was estimated was very low. Of equal interest was the opinion expressed by 24.1% of all respondents that they did not have such individuals in their patient loads.

The physicians responding to the survey expressed mixed feelings regarding expansion of the Vocational Rehabilitation agency in Montana. Of the respondents, 178 or 47.6% stated it should expand, 41 or 11.0% felt it should be maintained at the present level, 12 or 3.2% felt a reduction in program should be made, and 143 or 38.2% chose not to express a view.

H. To what extent do you feel that those having the following social handicaps can be rehabilitated?

The definition of the criteria to be applied to an individual before he can be considered "rehabilitated" is subject to interpretation and has not generally been resolved in rehabilitation. Vocational rehabilitation, however, has been historically considered to have been accomplished when the individual is placed in gainful employment. Despite the considerable latitude in definition of the term "rehabilitated," it was desired to have physicians rate certain social handicaps for rehabilitation potential. The following tables are presented as an indication of the rating of these conditions by degrees of potential with the numbers indicating the number of physicians so responding.

TABLE 59-F

ALCOHOLISM

	Completely	Partially	Seldom	Never	Uncertain	No Response
Region 1	11	15	30	27	2	1
Region 2	10	15	16	20	1	4
Region 3	9	15	48	17	0	3
Region 4	11	14	31	24	3	2
Region 5	2	8	24	10	0	1
TOTAL	43	67	149	98	6	11

TABLE 59-G

DRUG ADDICTION

	Completely	Partially	Seldom	Never	Uncertain	No Response
Region 1	11	7	21	40	5	2
Region 2	10	11	15	24	2	4
Region 3	10	7	34	31	4	6
Region 4	14	10	15	39	3	4
Region 5	3	8	14	18	1	1
TOTAL	48	43	99	132	15	17

TABLE 59-H

MENTAL ILLNESS

	Completely	Partially	Seldom	Never	Uncertain	No Response
Region 1	12	11	57	3	0	3
Region 2	9	2	44	9	0	2
Region 3	10	11	63	2	0	6
Region 4	10	9	54	6	1	5
Region 5	2	1	37	3	0	2
TOTAL	43	34	255	23	1	18

TABLE 59-I

MENTAL RETARDATION

	Completely	Partially	Seldom	Never	Uncertain	No Response
Region 1	14	2	47	17	3	3
Region 2	10	0	32	19	3	2
Region 3	10	0	51	21	3	7
Region 4	10	0	48	18	4	5
Region 5	2	0	31	6	2	4
TOTAL	46	2	209	81	15	21

TABLE 59-J

DELINQUENCY

	Completely	Partially	Seldom	Never	Uncertain	No Response
Region 1	14	18	34	11	1	8
Region 2	10	12	31	8	2	3
Region 3	11	14	53	6	1	7
Region 4	13	19	40	8	0	5
Region 5	3	13	24	2	1	2
TOTAL	51	76	182	35	5	25

TABLE 59-K

HABITUAL CRIMINALITY

	Completely	Partially	Seldom	Never	Uncertain	No Response
Region 1	13	6	9	32	14	12
Region 2	14	5	9	29	6	3
Region 3	11	1	12	49	7	12
Region 4	13	3	16	31	15	7
Region 5	3	2	6	24	6	4
TOTAL	54	17	52	165	48	38

COMMENTS AND CONCLUSIONS:

Physicians play important roles in the process of rehabilitation. They have a direct influence in the determination of which patients will receive the benefits of services that can be vital in total rehabilitation. While referrals of individuals can come from any person or agency, it is imperative from the standpoint of the patient that the attending physician be aware of all the resources of rehabilitation and that he make prompt referrals and utilize these resources. It becomes incumbent upon all practitioners in medicine and rehabilitation to be cognizant of the role each must play if rehabilitation is to occur economically and expeditiously. The Committee on Rehabilitation of the American Medical Association has emphasized that the physician's understanding and leadership is essential if his patients are to receive all the benefits that total rehabilitation has to offer.

In summary, it appears that of the physicians responding to the survey, a significant number feel that the program is successful in fulfilling its objectives. Of greater significance, however, is the large number, 39.7%, who felt unable to evaluate the program, and the vast majority who wish to be informed of action being taken by the agency. It is apparent that the agencies must take positive steps to strengthen relationships with the medical profession, and could make an excellent beginning by a program to keep physicians informed.

A strong, positive relationship appears between those feeling the agencies do a good job and the use of the agency as expressed by referral of patients. It also appears general practitioners are more familiar with the agencies than are specialists.

As could be expected, a significantly larger number, 75.0%, of general practitioners, as compared to 53.9% of specialists, had completed medical forms to establish patient eligibility for Vocational Rehabilitation services.

A positive correlation was found with a Chi Square of 58.8 obtained on comparing Question B with Question C-1, which tends to indicate that those physicians who have had more experience with the agency seem to have a more positive attitude towards its success. Communications between physician and agency seem to constitute a significant problem. The importance of the physician's role in the determination of eligibility seems unclear to many physicians, with 45.5% indicating they were aware that their opinions were a major determinate, versus 42.5% who felt they were not. The exact role of the physician must be clarified by the agency. General practitioners seemed more cognizant of the value of Vocational Rehabilitation services than did specialists, and seemed to identify more clients who could benefit from Vocational Rehabilitation services than did the specialists.

The lack of availability of services was recognized as would be expected, with the specialist group feeling more services were available than did the general practitioners. This probably reflects the actual situation, as most specialists are in urban areas with more ancillary services. It can be seen that with 20.0% reporting no physical therapy (a high of 53.3% in Region 5), a substantial number of injured and disabled do not have a most basic therapeutic service. Other services likewise are identified as being in very short supply.

The three most needed rehabilitative services statewide were indicated to be as follows in descending order:[2] physical therapy first, psychology second, and psychiatric social work third. Second choices were: occupational therapy first, psychiatric social work second, and a rehabilitation center third. Third choices were rehabilitation center first, special education teacher second, and vocational evaluation third.

The least needed services[3] were social work first, psychologist second, and halfway house third. Second choices were: halfway house first, social work second, and psychiatric social work third. Third choices were rehabilitation center first, halfway houses second, and treatment center third.

It is impossible to ascribe any significance to this rating schedule other than to give a gross indication of physician assessment of service needs.

The interpretation of responses to Question G must be made in recognition of the probability that those physicians antagonistic to the program perhaps did not respond to the questionnaire. However, a significant number appear to recognize the merits of the program as a means of reducing dependency and assisting the individual toward greater self-realization and thus support program expansion. Tables resulting from Question G must be interpreted with caution; however, it appears that overall there is considerable pessimism as to the rehabilitation potential of these groups which will receive increasing attention from Vocational Rehabilitation. The attitude of physicians in this regard is probably a reflection of society in general.

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[2] See Survey Questionnaire, Appendix C.

[3] See Survey Questionnaire, Appendix C.

Comparison with physician referrals in other inter-mountain states gives some indication of the relationship between physicians and the rehabilitation agencies in Montana. In Montana, 5.9% of all referrals to DVR are made by physicians, in Idaho 9.1%, in Colorado 7.4%, in Utah 9.5%, and in Wyoming 5.2%.[4]

It would appear from the evidence that Vocational Rehabilitation in Montana must initiate a program to enhance effective working relationships with the medical profession.

The physicians were given an opportunity to comment on the program of Vocational Rehabilitation. The following comments are grouped by subject matter and were selected for presentation to give a cross-section of response:

Value of Vocational Rehabilitation

> "Vocational Rehabilitation has been very successful for those of my patients who were mentally and emotionally able to utilize the training they received."
>
> "If able to rehabilitate certainly much more rational than to remain a constant drag on self and society."
>
> "A very valuable service which should be available to more people and in more variety than now seems to exist."
>
> "Should expand for necessary cases of severe or moderate handicapped, and not bother in minor illnesses that are not handicapping and clear usually."

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[4] Rehabilitation Services Administration, Characteristics and Trends of Clients Rehabilitated in Fiscal Year 1963-1967, Table 18C, p. 22, Division of Statistics and Studies, United States Department of Health, Education, and Welfare, Social and Rehabilitation Series.

"This agency is very important."

"Expand its services - on a very selective basis. Keep the goal of rehabilitation in mind. Don't just give financial aid to the needy."

Need for Vocational Training

"Need vocational school in this state very much."

"Desperate need for on-the-job training or short instruction courses for specific jobs."

"Need broader job selection for rehabilitating people. Possibly the state is too small, too little industry, etc. to provide a good selection for retraining."

"We have several paraplegias now in the hospital who have been through rehabilitation hospitals, but need further occupational training to become productive in society."

"Expand only into getting people back to work. I am sure more types of job training are necessary. Many patients I have talked to do not care to learn watch repair and that was their only choice."

Program Criticism

"In the past Vocational Rehabilitation has been extremely limited in what it could offer patients - too many ended up as barbers. I feel that many of these patients who have not had sufficient education could go on to some higher education and possibly clerical work if they didn't have to worry about finances during this period. They should get a subsistence that can feed and clothe their families adequately during this period of re-education."

"It should stop recruting people for the program who have minor physical abnormalities and no actual handicap - many of the people who come to me are in this category. Concentrate on those who really need it - rehabilitation of stroke cases and cardiac cases particularly."

"I believe that too much effort is wasted on minimally handicapped patients. I believe this is used as a crutch or graft by some patients, and question the judgment of the Vocational Rehabilitation Services in taking on the minimally handicapped patients."

Program Criticism (cont.)

"One patient was sent for what I thought were very good reasons - five children to support - and because of slow recovery from hepatitis plus emotional problems should have been rehabilitated. She was turned down. This will, in the end, cost the state more money."

"Expand services in light of the following recommendations: I feel that money is being wasted in 'rehabilitating' illness of a trivial nature. For example, well-controlled diabetics and idiopathic edemia of young females. Since money is limited it should be used to help people who have some potential and who have otherwise seriously limiting handicaps so that they can eventually be self-supporting."

"Somewhat greater selectivity should be exercised as too much money is spent on self-limited problems, not enough on special difficult rehabilitation cases; e.g., two of my patients with loss of use of one eye received considerable help in going to college (I did not recommend them to the program). They both came from families well able to finance their education. Another patient with paraplegia who has exhausted his own resources was rejected for rehabilitation (he needs muscle transplants--joint fusion, and special equipment) because the projected cost for this patient would have been too great."

Physicians Informational Programs

This sampling of comments shows that there is an urgent need for closer liaison between the Rehabilitation agencies and physicians. The medical profession should be better acquainted with the program and its purposes.

Nurses Survey

A survey of registered nurses in Montana was conducted during November and December of 1967 by the Statewide Planning office. The questionnaires were sent by mail to 900 nurses who are members of the Montana Nurses Association and represented about 25.0% of the total of 3,636 nurses in the state. In October the survey questions were pretested with both public and private nurses. (See Appendix for forms.)

A total of 493 questionnaires were returned, which is 54.8% of the 900 sent out in the single mailing. Partial analysis of the returns was made by the Department of Sociology of the University of Montana at Missoula. Data was compiled by county and by planning region.

TABLE 60

EMPLOYMENT CHARACTERISTICS OF 493 NURSES

	Classification			Employment Status				Type of Practice					
	RN	LPN	NR	Full Time	Part Time	Not Emp.	NR	Pri-vate	Doc/ Dent Ofc.	Hosp	Nrsg Home	Pub. Hlth	Other
Region 1	82	0	0	55	21	6	0	8	4	40	5	14	11
Region 2	118	0	1	83	25	9	2	7	6	60	4	22	20
Region 3	140	0	0	85	33	18	4	12	9	67	2	24	26
Region 4	95	0	1	65	21	7	3	7	3	52	7	10	17
Region 5	56	0	0	38	15	3	0	4	6	41	0	4	1
TOTAL	491	0	2	326	115	43	9	38	28	260	18	74	75

The greatest number of respondents were from Region 3, 28.4%; Region 2 was next, 24.1%; followed by Region 4, 19.5%; Region 1, 16.6%; and Region 5, 11.4%.

Of the nurses responding, 66.1% were working full time, 23.3% part time, and 8.7% were unemployed. Most of the private nurses, 71.1%, were working part time; 86.0% of the unemployed plan to return to nursing when personal conditions permit.

Over half of the nurses, 52.7%, were employed in hospitals; 15.0% were in public health; office and private categories total 13.4%; and 15.0% were in other employment.

TABLE 60-A

A. How long have you been employed in your profession?

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
Less than 1 yr.	0	0	4	0	0	4
1 - 3 yrs.	10	12	11	9	4	46
4 - 6 yrs.	6	9	4	4	3	26
7 - 9 yrs.	2	11	5	7	3	28
10 - 12 yrs.	6	10	14	15	1	46
More than 12 yrs.	55	75	101	60	45	336
No Response	3	2	1	1	0	7
TOTAL	82	119	140	96	56	493

An analysis of length of employment reveals that the most important characteristic of this group is that 68.2% of these nurses have been employed in their profession over 12 years; 24.5% have been with their present employers over 12 years; and 53.6% have been employed in this state more than 12 years. It would appear that a group with this experience in the health fields would have considerable knowledge of rehabilitation and services available to the disabled.

TABLE 60-B

B. Please state your highest level of education achieved.

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
High School	11	15	14	11	7	58
College less than BA	43	70	67	51	37	268
BA Degree	20	19	28	18	8	93
Some Graduate Work	4	3	6	6	3	22
Masters Degree	2	11	22	10	1	46
Ph.D. or Equivalent	0	0	1	0	0	1
No Response	2	1	2	0	0	5

The level of education indicates that over half, 54.4%, of the respondents have college or nurse's training but have less than a B.A. degree. This category ranges from 66.1% of respondents in Region 5 to 47.9% in Region 3; 18.9% of the sample held at least a B.A. degree, and 9.3% had a Master's degree. Many of the latter are teaching in the nursing field. When questioned about their opportunities for up-dating professional skills, 85.7% said they were allowed time to attend educational activities, and 70.3% said they had in-service training programs. Of the respondents, 58.6% were natives of Montana, probably most of them trained in this state.

TABLE 60-C

C. If you seldom or never refer disabled clients to the above agencies, please indicate why: (1) Ages below that accepted by DVR (currently 16 and over); (2) Ages above labor market potential; (3) No suitable referral system; (4) Not familiar with above agencies; (5) Disabilities encountered do not present barrier to employment; (6) Other.

D. If you have referred clients to above agencies, what is your estimate of success?

	RESPONSE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
C	1	2	3	7	4	1	17
	2	5	3	12	5	2	27
	3	8	12	13	15	13	61
	4	18	25	27	25	17	112
	5	12	10	11	7	4	44
	6	21	28	44	30	19	142
	NR	-	-	-	-	-	-
D	Good	12	9	16	11	2	50
	Fair	6	12	13	4	7	42
	Poor	0	1	1	0	0	2
	Don't know	7	17	16	12	6	58
	NR	57	80	94	69	41	341

In regard to why they had not made referrals, 58.8% of the respondents said they had not referred anyone to DVR in the past 12 months and 64.1% had not referred anyone to DBS in the same period. Many who did not make referrals commented that this was the doctors' responsibility. A very high percentage, 29.2%, said they did not refer patients because they were unfamiliar with the agencies, and an additional 15.6% thought there was no suitable referral system; 23.2% gave the latter reason in Region 5. This is confirmation that communications and services are not adequate particularly in the eastern part of the state, and this response is generally consistent with what has been found in the other project studies.

When asked to judge program success, 69.2% did not respond to the questions, and 11.8% said they did not know about success of rehabilitation of their patients. Of the remaining 19.1%, 10.1% said that success was good and 8.5% said it was fair. The most favorable responses came from Public Health nurses.

TABLE 60-D

E. Assuming availability of the following services, which would be of benefit to your clients:
(1) Individual rehabilitation counseling.
(2) Group counseling.
(3) Psychological testing.
(4) Vocational training.
(5) Psychiatric treatment.
(6) Job placement.
(7) Other.

F. If you are aware of disabled people who are not receiving services, what do you believe are the reasons:
(1) Lack of knowledge or information of available services.
(2) Cost of effort necessary to get services.
(3) Services inadequate or not available within geographic area.
(4) Apathy on part of client or family.

		REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
E	1	32	64	68	51	35	250
	2	10	28	28	18	11	95
	3	18	36	40	29	25	148
	4	26	51	56	32	27	192
	5	22	45	54	34	28	183
	6	18	45	54	27	17	161
	7	5	6	11	9	5	36
F	1	24	54	57	39	34	208
	2	19	16	30	15	17	97
	3	11	24	39	25	39	138
	4	27	47	50	33	28	185

Nurses from all regions said that individual rehabilitation counseling was the service which would most benefit their patients. Vocational training and psychiatric treatment were listed as the next most urgent needs.

Reasons given as to why the disabled don't receive services were as follows: Lack of knowledge or information on available service was a reason given by 33.2% of the respondents; 29.5% thought apathy on the part of the patient or family was responsible. Inadequate services was the most frequent reason given by Region 5 nurses. This again reflects a lack of services in that large area.

Nurse Comments

The nurses responding to the survey had wide and varied employment experience. Their comments give an overview of many areas of concern to this profession.

Needs

> "In our work with young men rejected at the Armed Forces Examination Station in Butte, we found that few of them knew of any services available in their communities. Many of the defects for which the armed services rejected these men had been known all through their school years. Some had had maximum correction, but it is my personal opinion either that we do not have necessary health services available to young children or we have not 'educated' the people to the value of good health."

> "I believe it would help if our doctors were more informed and interested and encouraged more action from the R.N.'s. Cardiac, vascular and stroke victims seem to be the most frequent patients seen that could be helped."

> "A program of activities for daily living for patients and families might enable the patients to leave the hospital sooner. Hospitals are not usually planned for the convenience of handicapped patients or the ward personnel who teach them to help themselves. If we had such a center, discharged patients could go there with their families and would be stimulated to keep up the motor functions they already have and to strive for more."

Needs (cont.)

"The V.A. sends patients who need speech therapy to Minneapolis. I wonder what happens to other people who need this service and whether there is enough need to warrant a community project?"

"I believe there is a need for more occupational therapy for patients who have been disabled, and have to change their line of work due to injury, and also for young people with congenital defects who have to stay in wheel chairs."

"A large percentage of my caseload desperately needs psychiatric evaluation and therapy. They could go to Helena or to a private psychiatrist but both call for more money than my lower class families have."

"Many low income persons need special rehabilitation to be readied for a job and its responsibilities. They need rehabilitation as badly as the man with no leg."

Vocational Rehabilitation

"There is a lack of continuity in follow-ups of referrals and communications of dispositions or progress reports are nil - part of this is due to lack of personnel, and in frequency of visits to local areas."

"Wherever I have had the opportunity to work with DVR, they have been most helpful and have done a real fine job."

"County public health nurses are frequently frustrated when they request DVR services for a patient. The delay in counselor contact, question of meeting criteria for service, and feedback on what is the status are major causes as I interpret them."

Informational Programs

"Most hospital personnel are unaware of availability of referral systems to any agency. Also the nurse feels this is in the area of physicians' services to patients. Perhaps public education would increase use of these agencies."

> "Even professional people in Butte are not aware of all of the services we have available to us here. The state as a whole is horribly ignorant of the advantages our people have available to them."
>
> "I feel most nurses are unaware in our area of any rehabilitation programs or services available as either patients are not encouraged to seek the help while in the hospital but informed of it later, or available facilities are not known to either doctor or nurse. I have felt the need of rehabilitation with stroke patients and their families."
>
> "I am not familiar with the services offered in Havre and I feel many people are in the same situation. Countless patients could profit if more nurses and physicians knew of the availability of such services."
>
> "I do not work with patients but with nurses, and it is my opinion that most staff nurses do not know very much about referral or services available in their own communities."

COMMENTS:

Nurses do not often refer patients for rehabilitation services unless they are in a school setting or are in a Public Health Department. The majority of respondent nurses are employed within hospitals where they work under the supervision and direction of the attending physician. The traditional working relationship of physician and nurse, of necessity, dictates that this be so and consequently this may be a reason that they do not make referrals to other agencies. The high percentage of response to this question in the "No suitable referral system," "Not familiar with DVR and DBS," and "Other" categories tend to substantiate this. This situation becomes very obvious in relation to the responses given to the same question by other professionals. Nurses by the nature of their employment and with the greater opportunity for the prolonged patient contact that it affords, are in an excellent position to increase patient awareness of rehabilitation programs, without inpinging upon the practices or ethics of the physician-nurse professional relationship.

Professional Personnel

The professional survey was intended to assess the characteristics of those persons engaged in rehabilitation and related activities and to ascertain certain broad aspects of the programs in which they function as they may relate to rehabilitation. Of equal interest was the determination of patterns of usage of rehabilitation services by these persons who together constitute one of the major sources of identification and referral of the disabled to the Division of Vocational Rehabilitation and the Division of Blind Services.

Agency employee lists and lists of members of professional organizations were used as the basis of the survey. A total of 519 questionnaires were mailed with 378 returned, for a 72.8% response to the single mailing. This response may be considered indicative of the interest of these persons in rehabilitation as well as an expression of their desire to participate in activities which offer opportunities to advance the cause of the disabled individual in the state.

Questionnaires were mailed to all individuals identified as being employment counselors, probation officers, high school counselors, occupational therapists, speech therapists, physical therapists, psychologists, rehabilitation counselors, social workers, special education teachers, and administrators in the service field. (See Appendix C for forms.) The forms were pretested in October of 1967 with all categories of professionals represented. The general mailing was made in November and December of 1967. Partial analysis of the data was made by the Sociology Department of the University of Montana at Missoula. Compilation was by county to allow analysis on a regional as well as on a statewide basis.

In tabulating the returns, 14 of the IBM cards were eliminated because respondent professionals were not residing in the state or because of processing error. As it was determined that the response was numerically biased in favor of school personnel, the respondents were further separated on the basis of school and other professionals and were so tabulated and reported. Of the 364 respondents, 176 (48.4%) were school personnel and 188 (51.6%) were other professionals.

TABLE 61

PROFESSIONAL PERSONNEL SURVEY
(NON SCHOOL RELATED)

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
Administration	10	13	10	11	7	51
Audiologist	1	1	1	1	1	5
Employment Counselor	4	7	5	7	1	24
High School Counselor	2	2	2	1	3	10
Juvenile Probation Officer	3	3	4	4	4	18
Occupational Therapist	3	2	3	3	1	12
Physical Therapist	6	6	9	5	1	27
Psychologist	0	0	0	0	1	1
Rehab Counselor	2	5	7	3	1	18
Speech Therapist	2	4	2	5	1	14
Social Worker	7	10	9	7	10	43
Other	12	2	7	4	2	27
No Response	1	0	1	0	1	3

A total of 188 professionals other than school personnel was tabulated. Some respondents replied in more than one employment category which indicates the dual responsibilities some fulfill. A total of 250 job categories are represented by the 188 respondents. Three respondents did not specify a job category.

Of the group, 84.0% were employed full time and only 6.0% were unemployed. One important deviation was in the occupational therapy group where 50.0% were unemployed and only 16.7% were employed full time.

TABLE 61-A

A. How long have you been employed in your profession?

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
Less than 1 yr.	2	2	3	4	1	12
1 - 3 yrs.	13	22	10	9	3	57
4 - 6 yrs.	9	5	9	4	1	28
7 - 9 yrs.	7	2	3	5	4	21
10 - 12 yrs.	1	1	4	11	3	20
More than 12 yrs.	8	7	18	5	8	46
No Response	0	2	0	1	1	4
TOTAL	40	41	47	39	21	188

The largest number of the respondents statewide have been employed between 1 and 3 years and the second largest group for 12 or more years. All personnel having experience of 12 or more years constituted 24.5% of the group; 30.3% had 1 to 3 years experience; 14.9% had 4 to 6 years experience; 11.2% had 7 to 9 years experience; and 10.6% had 10 to 12 years experience.

Administrators have been employed in their profession for a median of 8.45 years and the employment counselors have been employed a median of 2.8 years in their profession. The physical therapists have a median of 5.45 years in their careers. The social workers have a median of 9.74 years and the "other" category has a median of 7.3 years.

The median length of employment for these professionals in Montana as a whole is 6.14 years. It appears that the employment counselors have fewer years in their profession than do any of the other categories for which medians have been calculated. This trend is consistent among all the regions. The social workers seem to have the most years of service while the administrators follow with a close second.

TABLE 61-B

B. Please state your highest level of education achieved.

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
High School	2	0	1	0	1	4
College less than BA	4	2	5	6	6	23
BA Degree	16	17	17	14	9	75
Some Graduate Work	7	10	10	7	4	38
Masters Degree	6	8	9	8	6	37
Ph.D. or Equivalent	6	0	1	3	0	10
No Response	1	0	0	0	0	1

Of the sample, 39.9% have Bachelor's degrees and 19.7% have Master's degrees. A further analysis of the questionnaires indicates that those in the categories of administration, audiology, and speech therapy seem to have the most formal education. This is a reflection of the professional upgrading which is occurring notably in the fields of audiology and speech therapy. The certification standards of these professions will eventually require a Master degree. This group also has the majority of those at the Doctoral level.

TABLE 61-C

C. If you seldom or never refer disabled clients to the above agencies, please indicate why: (1) Ages below that accepted by DVR (currently 16 and over); (2) Ages above labor market potential; (3) No suitable referral system; (4) Not familiar with above agencies; (5) Disabilities encountered do not present barrier to employment; (6) Other.

D. If you have referred clients to above agencies, what is your estimate of success?

	RESPONSE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
C	1	9	6	6	11	4	36
	2	2	5	2	1	1	11
	3	0	5	2	2	3	12
	4	0	3	4	2	0	9
	5	3	7	2	4	2	18
	6	6	7	4	11	7	35
	NR	-	-	-	-	-	-
D	Good	22	20	22	19	8	91
	Fair	10	12	11	12	6	51
	Poor	1	2	3	2	4	12
	Don't know	5	3	3	5	1	17
	NR	2	6	6	1	2	17

The single reason cited most often for non-referral to DVR and DBS was age. The greatest significance seems to be that the majority do make referrals and that referral channels are open and are used. Few admit that non-referral is based upon their lack of familiarity with the agency, this despite the number who indicate they wish more information. This might indicate that a rather cursory knowledge exists rather than a detailed understanding of DVR and DBS functioning. By professional groups, it is found that 25.0% of the juvenile officers and 23.1% of the physical therapists indicate they are not familiar with the above agencies. It is not unusual that this exists among such a significant number of juvenile officers but is startling when related to physical therapists who deal in one of the most basic therapies and one that DVR particularly utilizes for the large number of orthopedic patients they serve.

During the preceding 12 months, 60.8% of those questioned had made referrals to DVR and 35.2% had made referrals to DBS. Of those responding, 48.4% indicated that rehabilitation agency success was good. The range on this question was from 55.0% in Region 1 to 38.1% in Region 6; statewide 27.1% felt the agencies did a fair job; 6.9% indicated a poor rating; and 9.0% did not know how successful they were.

TABLE 61-D

E. Assuming availability of the following services, which would be of benefit to your clients:
  (1) Individual rehabilitation counseling.
  (2) Group counseling.
  (3) Psychological testing.
  (4) Vocational training.
  (5) Psychiatric treatment.
  (6) Job placement.
  (7) Parental or family counseling.
  (8) Other.

F. If you are aware of disabled people who are not receiving services, what do you believe are the reasons:
  (1) Lack of knowledge or information of available services.
  (2) Cost of effort necessary to get services.
  (3) Services inadequate or not available within geographic area.
  (4) Apathy on part of client or family.

		REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
E	1	26	26	31	25	17	125
	2	9	14	15	13	8	59
	3	20	23	25	25	18	111
	4	35	35	37	34	20	161
	5	21	22	21	15	12	91
	6	27	26	35	25	15	128
	7	32	28	21	22	18	121
	8	3	7	7	0	0	17
F	1	23	35	22	23	18	121
	2	12	6	8	2	5	33
	3	22	31	23	17	15	108
	4	22	22	23	22	10	99

The services of a specialized nature that are considered necessary to the disabled by the respondents show variations as would be expected; however, the critical need for vocational training was cited as most needed in all regions, and rather uniformly so by this group of individuals. Surprisingly, this group gave a higher priority to vocational training than did the school personnel, who might be considered to be more cognizant of needs related to education.

The following are the rank orders of the services listed for this question. The services are ranked by region and for the state as a whole.

Region I

1	VT	20.2%
2	PFC	18.5%
3	JP	15.6%
4	IRC	15.0%
5	PTr	12.1%
6	PTest	11.6%
7	GC	5.2%
9	0	1.7%

Region II

1	VT	19.3%
2	PFC	15.5%
3	JP	14.4%
3	IRC	14.4%
4	PTest	12.7%
5	PTr	12.2%
6	GC	7.7%
7	0	3.9%

Region III

1	VT	19.3%
2	JP	18.2%
3	IRC	16.1%
4	PTest	13.0%
5	PFC	10.9%
5	PTr	10.9%
6	GC	7.8%
7	0	3.6%

Region IV

1	VT	21.4%
2	IRC	15.7%
2	PTest	15.7%
2	JP	15.7%
3	PFC	13.8%
4	PTr	9.4%
6	GC	8.2%
6	0	0.0%

Region V

1	VT	18.5%
2	PFC	16.7%
2	PTest	16.7%
3	IRC	15.7%
4	JP	13.9%
5	PTr	11.1%
6	GC	7.4%
7	0	0.0%

Montana

1	VT	19.8%
2	JP	15.5%
3	IRC	15.4%
4	PFC	14.9%
5	PTest	13.5%
6	PTr	11.3%
7	GC	7.3%
8	0	2.1%

"Individual rehabilitation counseling" is consistently in third or fourth place except that it is second in the rank order for Region IV. Job placement also ranks high as a basic need.

KEY:

IRC -- Individual rehabilitation counseling
GC -- Group counseling
PTest -- Psychological testing
VT -- Vocational training
PTr -- Psychiatric treatment
JP -- Job placement
PFC -- Parental or family counseling
0 -- Other

The professionals seem to feel that disabled do not receive services because of the client's lack of knowledge of services that are available, as well as a shortage or lack of needed services. A rather large percentage feels that apathy is also a significant factor which would not be surprising when related to the lack of services available to an individual. Obviously, a high level of motivation cannot be maintained if the individual cannot gain access to what he needs to assist himself.

TABLE 62

SCHOOL PERSONNEL

	Administration	Employment Counselor	High School Counselor	Speech Therapist	Other
Region 1	11	0	22	2	14
Region 2	15	1	26	1	10
Region 3	5	0	15	1	15
Region 4	12	1	23	0	17
Region 5	4	0	21	2	13
TOTAL	47	2	107	6	66

The total number of school personnel is 176. Some of the respondents replied to more than one of the professional categories as indicated by the total number which shows up on the summary charts as 228 because of having positions of multiple responsibilities.

The breakdown for the school personnel sample is as follows: administration, 20.6%; employment counselor, 0.9%; high school counselor, 46.9%; speech therapy, 2.6%; and other, 28.9%. Special education teachers compose the majority of the "other" response.

TABLE 62-A

A. How long have you been employed in your profession?

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
Less than 1 yr.	3	2	4	4	5	18
1 - 3 yrs.	6	11	3	7	5	32
4 - 6 yrs.	5	5	5	5	6	26
7 - 9 yrs.	6	7	6	6	4	29
10 - 12 yrs.	5	5	0	4	3	17
More than 12 yrs.	11	11	8	17	7	54
TOTAL	36	41	26	43	30	176

School personnel having employment experience of 12 or more years constitute 30.7% of the group, and this is rather consistent throughout the regions with a range of 23.3% in Region 5 to 39.5% in Region 4. Administrators have considerable experience with 57.5% of them having over 12 years. Of the total group, 18.2% had 1 to 3 years experience; 14.8% had 4 to 6 years; 16.5% had 7 to 9 years; and 9.7% had 10 to 12 years experience.

TABLE 62-B

B. Please state your highest level of education achieved.

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
High School	1	0	0	0	0	1
College less than BA	0	2	1	0	0	3
BA Degree	1	3	3	3	6	16
Some Graduate Work	7	10	7	13	9	46
Masters Degree	24	26	15	24	17	106
Ph.D. or Equivalent	2	0	1	1	0	4

In the sample, 60.2% of the school personnel have Master's Degrees. Within the administrator's category, 91.5% have Master's Degrees. A total of 26.1% of the remainder have some graduate work and only 9.1% have just a Bachelor's Degree. Range by region for the Master's Degrees of the total group is 68.6% in Region 1 and 53.1% in Region 5. Remaining statewide categories are "college less than a BA" 1.7%; "high school" 0.6%; and "Ph.D. or equivalent" 2.3%.

TABLE 62-C

C. If you seldom or never refer disabled clients to the above agencies, please indicate why: (1) Ages below that accepted by DVR (currently 16 and over); (2) Ages above labor market potential; (3) No suitable referral system; (4) Not familiar with above agencies; (5) Disabilities encountered do not present barrier to employment; (6) Other.

D. If you have referred clients to above agencies, what is your estimate of success?

	RESPONSE	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
C	1	14	22	9	20	13	78
	2	1	0	0	0	0	1
	3	1	3	4	4	1	13
	4	0	1	4	6	5	16
	5	5	3	5	5	12	30
	6	7	9	2	6	5	29
	NR	-	-	-	-	-	-
D	Good	17	13	6	10	6	52
	Fair	5	12	4	8	3	32
	Poor	0	2	1	0	4	7
	Don't know	10	10	11	14	11	56
	NR	4	6	4	9	6	29

The highest number of respondents, 46.7%, indicates they do not refer cases because of "age below DVR acceptance," which would be expected of the school population. The categories of "disabilities encountered do not present a barrier to employment" are related to the same cause. The combined number indicating "no suitable referral system" or "not familiar with the agencies" indicates additional contact work by the Vocational Rehabilitation agencies is needed. Referrals to DVR in the prior 12 months were made by 48.7% of the respondents and to DBS by 10.5%.

Of the respondents, 29.5% felt that the success of the DVR and DBS could be classified as "good." The reports of good success ranged from 47.2% in Region 1 to 20.0% in Region 5.

It seems that the respondents from Region 1 were more satisfied with the program than were the respondents from the other regions.

TABLE 62-D

E. Assuming availability of the following services, which would be of benefit to your clients:
(1) Individual rehabilitation counseling.
(2) Group counseling.
(3) Psychological testing.
(4) Vocational training.
(5) Psychiatric treatment.
(6) Job placement.
(7) Parental or family counseling.
(8) Other.

F. If you are aware of disabled people who are not receiving services, what do you believe are the reasons:
(1) Lack of knowledge or information of available services.
(2) Cost of effort necessary to get services.
(3) Services inadequate or not available within geographic area.
(4) Apathy on part of client or family.

		REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	TOTAL
E	1	16	22	9	23	11	81
	2	8	16	6	15	10	55
	3	10	26	3	10	9	58
	4	28	29	18	28	20	123
	5	15	20	5	10	8	58
	6	19	16	19	22	10	86
	7	34	36	23	26	21	140
	8	0	4	3	4	1	12
F	1	23	35	22	23	18	121
	2	12	6	8	2	5	33
	3	22	31	23	17	15	108
	4	22	22	23	22	10	99

Parental or family counseling and vocational training were considered by educators to be the most needed of specialized services.

The following are the rank orders of services listed from the services thought to be most useful.

Region I

1	PFC	26.2%
2	VT	21.5%
3	JP	13.6%
4	IRC	12.3%
5	PTr	11.5%
6	PTest	7.7%
7	GC	6.2%
8	O	0.0%

Region II

1	PFC	21.3%
2	VT	17.2%
3	PTest	15.4%
4	IRC	13.0%
5	PTr	11.8%
6	GC	9.5%
6	JP	9.5%
7	O	2.4%

Region III

1	PFC	26.7%
2	JP	22.1%
3	VT	20.9%
4	IRC	10.5%
5	GC	7.0%
6	PTr	5.8%
7	PTest	3.5%
7	O	3.5%

Region IV

1	VT	20.3%
2	PFC	18.8%
3	IRC	16.7%
4	JP	15.9%
5	GC	10.9%
6	PTest	7.3%
6	PTr	7.3%
7	O	2.9%

Region V

1	PFC	23.3%
2	VT	22.2%
3	IRC	12.2%
4	GC	11.1%
4	JP	11.1%
5	PTest	10.0%
6	PTr	8.9%
7	O	1.1%

Montana

1	PFC	22.8%
2	VT	20.1%
3	JP	14.0%
4	IRC	13.2%
5	PTest	9.5%
5	PTr	9.5%
6	GC	9.0%
7	O	2.0%

KEY:

IRC -- Individual Rehabilitation Counseling
GC -- Group Counseling
PTest -- Psychological Testing
VT -- Vocational Training
PTr -- Psychiatric Treatment
JP -- Job Placement
PFC -- Parental or Family Counseling
O -- Other

Concerning reasons that some disabled are not receiving services, 33.5% of the respondents answered that lack of knowledge regarding services was a deterrent and 29.9% felt inadequate or unavailable services within the area was a significant reason. Family or client apathy was identified by 27.4% as the primary reason.

COMMENTS AND CONCLUSIONS:

Of all the school personnel responding, 91.2% are full time employees as compared to 84.2% full time employees for the other professionals. Only 50.0% of the registered occupational therapists responding are employed full time. This may be indicative of the lack of understanding and appreciation of the contribution of occupational therapy to the rehabilitation process by not only physicians but administrators of hospitals and facilities, as well as by related professionals. This assumption gains support when it is found that the desire for more information on occupation therapy ranked third after the DVR and psychiatric social work when respondents were asked if they would like information on specific fields.

The survey did not identify with any significance the reasons for unemployment, primarily because of the low number of respondents who are unemployed. It could be assumed that non-employed professionals would not be motivated to return the questionnaire.

Natives of Montana account for 57.4% of all respondents, and in general it can be said that those reporting the highest academic qualifications are non-natives.

Most respondents felt they have average client or student loads according to the standards of their profession; however, 10.0% considered them to be excessive. Over 80.0% of all respondents indicated they were allowed time off to attend professional meetings. Only 46.5% of the school people reported they had in-service training programs as compared to 64.0% of the other professionals. Other comparative results show that in terms of length of employment, 30.7% of the school people, versus 24.5% of the other professionals, have been employed 12 or more years in their professions; 18.5% of the school people, versus 30.3% of the other professionals, had 1 to 3 years; 14.8% of school, versus 14.9% of other professionals, had 4 to 6 years; 16.5% of school, versus 11.2% of other professionals, had 7 to 9 years; and 9.7% of school, versus 10.6% of other professionals, had 10 to 12 years.

Master's Degrees were held by 60.2% of school people and 19.7% of other professionals. Of the latter group, 39.9% held B.A.'s and 9.1% of school people were in this category.

Most respondents were unable to evaluate results of rehabilitation services for those they had referred. However, 22.4% of the school people and 36.4% of other professionals considered results good. Just 3.1% of the school personnel and 3.7% of others considered results poor. In general, Region 1 professionals considered results very good, while Region 5 reported more poor results than any other section.

When asked what services would benefit their clients most, school personnel ranked parental or family counseling first and vocational training second. Other professionals ranked vocational training first in all regions and job placement second.

Lack of knowledge of available services was given by the professional group as the biggest single reason for some disabled not receiving services. Inadequate services or apathy on the part of the client or family were also cited as deterrents.

In general, the respondents in Region 5 were less aware of rehabilitation activities and reported less rehabilitation work in progress than the rest of the state.

Comments were solicited from those responding to the survey and the following were selected as indicative of problems identified:

Rehabilitation Needs

"I feel our greatest need in Montana is an in-patient rehabilitation center where severe disabilities can be treated with training for physical, social, and vocational rehabilitation."

"Montana needs a centralized Rehabilitation Center to serve all Montana; a complete service."

"We are much in need of some kind of sheltered work shop, or some program whereby these boys and girls can learn a trade to cope with the society in which they live."

"I feel there is a great need for vocational training for those physically handicapped over 16."

"I believe there is much need for child guidance and family counseling centers in the area."

"Most of my work is with older special education students. Many of these come back to us even after school years for counseling. I have also been asked to help the American Legion in rehabilitating several veterans who have been transferred to local nursing homes. I am most happy to do this but need help on occupational and recreational therapy."

"We need special education for our educable mentally retarded. We need vocational schools available within geographic area - our limited area schools make it necessary for students to get post-graduate training out of state."

"The 'hard core' unemployed (disabled) need concentrated effort; first for testing as to their capability (physical and mental), second, job placement services (including motivation). Presently the counselor does not have the time needed for these cases."

Rehabilitation Needs (cont.)

"The greatest need that is presently not met for students is adequate mental health facilities."

"The need is very great for vocational schools in Eastern Montana; also psychiatric help is hard to obtain here."

"In my position, retardation and lack of vocational training are the greatest problems."

Vocational Rehabilitation

"It appears that Vocational Rehabilitation needs to place a greater effort on helping to locate a job for some of their trainees once they have completed their training. Vocational Rehabilitation's plan for the person seems to be somewhat weak in this area. There is no sense training a person for an occupation unless you can place him on the job upon his completing his training."

"Working relationships with Vocational Rehabilitation office have been excellent and cooperation has been very good."

"As a public welfare agency, we refer whom we can to DVR and DBS, but circumstances such as small children in the home, non-cooperating doctors, and lack of clients with I.Q.'s from 70 to 100 make referral a waste of time. Of those clients we have referred, we have had immediate response and action from DVR and are greatly pleased."

"Services of Vocational Rehabilitation usually require a person to support himself while in training, which requirement makes it impossible for applicant to take advantage of training."

"I feel more people should become acquainted with the services of Vocational Rehabilitation."

"Montana needs more vocational counselors to cover this part of the state. We are serviced from Billings, 140 miles away, once a year (in the town of Wilsall)."

"Mr. ________________ of the DVR has been very helpful. I do feel his caseload is ridiculously high."

CLOSED CASELOAD STUDY

A study of Division of Vocational Rehabilitation cases, closed after services but not rehabilitated, in the fiscal year 1966-67, was conducted by two former Division of Vocational Rehabilitation counselors. The study included Status 30 (closed before a rehabilitation plan was made) and Status 28 (closed after a rehabilitation plan was drawn up). A questionnaire form (see appendix) was filled out for each client on the basis of case file information. A total of 152 cases closed during the period were studied. Six of the clients died during the period, leaving 146 whose cases were reviewed. Cases in Status 30 and 28 constituted 19.8% of the total cases closed during the year by the Division of Vocational Rehabilitaion.

In regard to general characteristics, the clients closed without being rehabilitated did not differ significantly from those closed as rehabilitated.

Of the [illegible] studied, 72.6% were male, compared to 69.6% of those rehabilitated in the same period.

There were 72.6% living in urban areas and the balance of 27.4% were in rural areas. No comparable figures on the rehabilitated group are available as DVR does not maintain statewide records of this type.

The median age was 31.48 in comparison to the rehabilitated group average of 31.

Orthopedic disabilities were most prevalent, with 28.8% of the non-rehabilitated being in this group, compared to 36.7% of the rehabilitated group. By contrast, 17.8% of the non-rehabilitated group were mentally retarded as compared to 4.9% of those rehabilitated who were so disabled. Heart and circulatory conditions were reported in 10.9% of the group compared with 10.5% of those rehabilitated.

There were 10.3% reported to have mental illness and 9.1% were identified in this category as rehabilitated.

The following judgments of the case reviewers give some insight into the characteristics and needs of these 146 cases. Individual case mobility was the major reason for removing clients from the caseload prior to rehabilitation. Of these, 32.2% moved to other locations, presumably most of them beyond the jurisdiction of the Montana Division of Vocational Rehabilitation. In 13% of the cases, the disability was judged too severe to rehabilitate. However, in just 4.1% of all cases was the decision to close the case based on medical evidence, which further emphasizes the importance of non-medical factors as determinants of vocational rehabilitation services.

Significant related problems were studied in each case, and by far the most prevalent was lack of interest on the part of the client, 17.1%, and on the part of the family, 13.0%.

Age was given as a significant factor in 6.2% of the cases. With the number of senior citizens increasing constantly, this is an area which will require more attention by the Division of Vocational Rehabilitation and related agencies. Multiple disabilities, 6.2%, and lack of client finances, 5.5%, were also considered as significant contributing factors to failure to achieve rehabilitation. Antisocial behavior was considered a factor in 8.2% of the cases, which indicates a need for other than medical services, if these problems are to be dealt with.

In 39.7% of the cases, the reviewers judged that rehabilitation could have resulted if unlimited services and funds had been available.

Additional services deemed necessary to properly serve those who could have been successfully rehabilitated included special medical supervision, maintenance, social casework, family counseling, and vocational training. Suitable vocational training was mentioned most often. A total of 30.8% of those needing additional services were in this category.

The reviewers agreed with the counselors' judgment in closing the clients in almost all cases, given the circumstances which prevailed at closing. Percentage of the reviewers' agreement with the counselors ultimate decision was 97.3%. This may be an indication of similarity of counselor-reviewer bias, or it may indicate a high degree of accuracy of judgment on the part of the counselor when the case was closed. The question becomes academic however when in-depth studies are conducted with all needed services and facilities available.

Actual cost to the Division of Vocational Rehabilitation was under $24.00 per client in 63% of the cases. This means that many cases received no service beyond the authorized physical examination and many either moved or effected other changes prior to extensive service. Another 9.6% were closed prior to the Division of Vocational Rehabilitation spending $50.00. Expenditures in excess of $1,000.00 were made in 6.8% of cases. Most cases closed in this category were participants in a special project at Boulder, serving severely retarded clients. This factor also accounts for the three to one ratio of mentally retarded cases to other disabilities referred to previously.

In 56.8% of the cases involved, agencies other than the Division of Vocational Rehabilitation expended funds. Of those receiving aid from other agencies, 25.3% were assisted by the Department of Public Welfare, while 58.9% did not identify the agency that had expended funds.

Of those rehabilitated during the year, 18% had referred themselves to the agency, and 15.6% were referred by other individuals (not agencies). For the non-rehabilitated group, only 9% referred themselves while 23.7% were referred by other individuals. This would indicate that there was more motivation to succeed on the part of those who were interested enough to initiate contact with DVR without intervention of a third party.

The study did indicate that success in rehabilitation could be substantially improved if Montana could provide many of the specialized services that are available elsewhere.

TABLE 63
NON-REHABILITATED CLIENT CHARACTERISTICS
CLOSED CASELOAD STUDY
BY SEX

Sex	Non-Rehabilitants		Rehabilitated Cases	
	Number	Percent	Number	Percent
Male	104	72.6%	429	69.6%
Female	40	27.4%	187	30.4%
TOTAL	146	100.0%	616	100.0%

TABLE 64
RESIDENCE

	Non-Rehabilitants	
	Number	Percent
Urban	106	72.6%
Rural	35	23.9%
Blank	6	3.4%
TOTAL	146	100.0%

It is significant that according to the 1960 census, the proportion of urban and rural residence in the state is almost evenly divided; 50.2% of the state population was listed as urban at that time.* As it appears here, the urban class far outnumbers the rural class.

What this means is that many rural residents are not adequately served by this program or at least they do not get involved as readily as urban residents. It seems unlikely that rural occupations would be as much less hazardous as the caseload study ratio might suggest.

TABLE 65

AGE AT CLOSURE

Age	Number	Percent of Total
60 & Over	2	1.4%
50 - 59	21	14.4%
40 - 49	20	13.7%
30 - 39	33	22.6%
20 - 29	47	32.2%
16 - 19	17	11.6%
Under 16	1	.7%
Unknown	3	2.1%
Blank	2	1.4%
TOTAL	146	100.0%

The median age for this group is 31.48. The median age for the whole state as of the 1960 census reports was 27.4 years. This shows that the age distribution for the closed caseload study is a bit older than the population as a whole. The majority of rehabilitated cases of the agency is in the 34 or younger age group, 431 of 616; 85 were in the 35 to 44 age group; 97 in the 45 to 64 age group; and only 3 were 65 or over.

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*Urban residence as used by the 1960 census included all incorporated places of 2,500 or above. It also includes all densely settled urban fringes, whether incorporated or unincorporated, of urbanized areas.

TABLE 66

NUMBER OF DEPENDENTS PER CLIENT NON-REHABILITANTS

Dependents	Number of Cases	Percent of Total
1	13	8.9%
2	9	6.2%
3 - 4	10	6.8%
5 - 6	8	5.5%
Over 6	5	3.4%
Unknown	33	22.6%
Blank	68	46.6%
TOTAL	146	100.0%

The rehabilitants during this period had dependents as follows: 343 had none; 68 had 1 dependent; 129 had 2 or 3; and 76 had 4 or more dependents. The median number of dependents was 3.

TABLE 67

EDUCATIONAL LEVEL

Years Completed	Number of Cases	Percent of Total
Under 6th	10	6.8%
6 - 8	26	17.8%
9 - 11	26	17.8%
H.S. Diploma	39	26.7%
Some College	4	2.7%
2 Yrs. College	4	2.7%
B.A.	0	-
Unknown	33	22.6%
Blank	4	2.7%
TOTAL	146	100.0%

The median number of school years ever completed for the whole state according to the 1960 census reports was 11.6 years. Thus the group considered here may be slightly but not significantly below the present state median.

TABLE 68

DISABILITY CATEGORY

Disability	Number of all Conditions	Percent	Number of Primary Conditions Rehabilitated by DVR (1)
Orthopedic	45	30.8%	217
Arthritis	13	8.9%	17
Visual Impairments	11	7.5%	31
Amputations	5	3.4%	35
Hearing Impairments	13	8.9%	41
Cardiac, Heart & Stroke	14	9.6%	67
TB & Other Respiratory	8	5.5%	12
Epilepsy	10	6.8%	16
Speech Impairments	13	8.9%	7
Diabetes	2	1.4%	13
Alcoholism	14	9.6%	8
Drug Addiction	0	0.0%	0
Mental Illness	25	17.1%	29
Mental Retardation	26	17.8%	30
Delinquency	8	5.5%	NA
Habitual Criminal	1	.7%	NA
Other	82	56.2%	92
TOTAL	290		616

As can be noted, there was a preponderance of "orthopedic" and "other" disability conditions in the non-rehabilitated group. The total of 290 indicates the high prevalence of multiple disabilities in the group studied. "Mental Illness" and "Mental Retardation" are also frequent disabilities in the group. A direct comparison with those closed as rehabilitated by DVR in the 1966-67 fiscal year is not possible due to the reporting practice of that agency which indicates only a primary disability. However, the number of persons rehabilitated by primary disability is presented for informational purposes. It is known that many of the rehabilitated group also have multiple disabilities.

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(1) Source: Form R301 fy 1966-67, Montana Division of Vocational Rehabilitation.

TABLE 69

REASONS NOT SERVICED TO SUCCESSFUL CONCLUSION

Reason	Reviewer I		Reviewer II	
	Number	Percent	Number	Percent
Client Moved	47	32.2%	47	32.2%
Client Deceased	6	-	6	-
Disability too Severe	17	11.6%	19	13.0%
Multiple Disability	11	7.5%	2	1.4%
Disability Combined With Age	11	7.5%	4	2.7%
Client or Family too Migratory	1	.7%	-	-
Not Financially Able to Assist	2	1.4%	-	-
Alcoholism	10	6.8%	5	3.4%
Antisocial Behavior	4	2.7%	1	.7%
Lack of Interest on Part of Family	1	.7%	1	.7%
Other	8	5.5%	16	1.9%
TOTAL NUMBER	118		101	

The six deceased members of the sample were not included in the total and thus no percentages could be computed for them.

The "Client Moved" category seems to be the most important as a reason for not completing services.

The "Multiple Disability," "Disability Combined with Age," "Disability too Severe," and "Not Financially Able to Assist" categories, aside from medical considerations, have relationship to inadequate financial resources needed to support the necessary facilities of a specialized nature. If more services were available in the form of financial, counseling, and medical help, these people may have been rehabilitated.

The categories related to "Alcoholism" and "Antisocial Behavior" while not the largest in number definitely point to areas which need additional attention.

TABLE 70

RELATED PROBLEMS OF SIGNIFICANCE IN CASE

	Reviewer I		Reviewer II	
	Number	Percent	Number	Percent
Age	9	6.2%	9	6.2%
Migratory	2	1.4%	12	8.2%
Antisocial Behavior	4	2.7%	12	8.2%
Lack of Interest of Client	31	21.2%	25	17.1%
Lack of Interest of Family	-	-	19	13.0%
Multiple Disabilities	9	6.2%	9	6.2%
Lack of Finances -- Client	10	6.8%	8	5.5%
Lack of Finances -- Agency	7	4.8%	1	.7%
Other	11	7.5%	40	27.4%
TOTAL NUMBER	83		135	

The age factor is shown to be quite significant here. This demonstrates that more work might be done with the older segment of our population.

There may be little that can be done for migratory people other than making services available in areas which would be easily accessible to them.

The "Antisocial Behavior" is an area which shows great potential as far as rehabilitation is concerned. It is an area of disability which cannot be ignored.

The "Lack of Interest on the Part of the Client" and "Lack of Interest on the Part of the Family" together form the largest category. The "Lack of Interest -- Client" category is by far the most important of the two.

Multiple disabilities represented 6.2% of the survey population. This is another area where more effort in terms of service and facilities should be made available for rehabilitation.

TABLE 71

DO YOU THINK THIS CLIENT COULD HAVE BEEN REHABILITATED IF UNLIMITED REHABILITATION RESOURCES AND FUNDS WERE AVAILABLE TO HIM?

Answer	Number	Percent
Yes	58	39.7%
No	68	46.6%
Do Not Know	5	3.4%
Cannot Determine	11	7.4%
Blank	4	2.7%
TOTAL	146	100.0%

The reviewers indicated they felt that 40.0% of the cases could have been rehabilitated if unlimited resources and funds had been available. This high percentage would indicate a great need for more funds and more facilities accessible to the agency and its clients.

TABLE 72

IF ANSWER IS "YES", CHECK ADDITIONAL SERVICES THAT ARE NEEDED:

Service	Reviewer I		Reviewer II	
	Number	Percent	Number	Percent
General Medical Supervision	2	1.4%	1	.7%
Special Medical Supervision	9	6.2%	16	10.9%
Rehabilitation Nursing	-	-	-	-
Physical Therapy	2	1.4%	1	.7%
Occupational Therapy	1	.7%	-	-
Prosthetic and Orthotic Services	2	1.4%	-	-
Speech and Audiology Services	2	1.4%	6	4.1%
Laboratory and X-Ray	-	-	-	-
Room and Board	1	.7%	17	11.6%
Infirmary Care	-	-	-	-
Dental Services	2	1.4%	-	-
Counseling	52	35.6%	6	4.1%
Psychiatric Treatment	19	13.0%	9	6.2%
Psychological Testing	1	.7%	2	1.4%
Vocational Evaluation	-	-	13	8.9%
Social Casework	11	7.5%	27	18.5%
Family Counseling and Guidance	4	2.7%	26	17.8%
Activity of Daily Living Therapy	1	.7%	-	-
Supervised Rec. & Soc. Activities	23	15.7%	2	1.4%
Special Academic Instruction	1	.7%	1	.7%
Limited Vocational Training	15	10.3%	25	17.1%
Full-Time Vocational Training	52	35.6%	20	13.7%
Halfway House	9	6.2%	8	5.5%
Other	8	5.5%	42	28.8%
TOTAL NUMBER	217		222	

TABLE 73

DO YOU AGREE WITH THE COUNSELOR'S REASONING USED IN CLOSING THIS CASE?

Answer	Number	Percent
Yes	142	97.3%
No	-	-
Blank	4	2.7%
TOTAL	146	100.0%

For a large majority of the cases, the reviewers agree with the rationale used by the original counselor.

TABLE 74

HOW MUCH MONEY WAS EXPENDED BY THE DIVISION OF VOCATIONAL REHABILITATION?

Dollars	Number	Percent
0 - 24	92	63.0%
25 - 49	14	9.6%
50 - 99	3	2.1%
100 - 249	10	6.8%
250 - 499	8	5.5%
500 - 1,000	8	5.5%
Over 1,000	10	6.8%
Blank	1	.7%
TOTAL	146	100.0%

The single most important category in this scale is the "0 - 24" category. Sixty-three percent of the cases fell in this group, as would be expected.

TABLE 75

IS THERE INDICATION THAT OTHER AGENCIES EXPENDED FUNDS?

Answer	Number of cases	Percent
Yes	83	56.8%
No	59	40.4%
Blank	4	2.7%
TOTAL	146	100.0%

The fact that 56.8% of the cases involved expenditures of funds by other agencies, indicates that many cases involve multiple factors treated by any number of separate agencies. Under such circumstances it can be surmised that a closer degree of coordination between agencies might effect a more economical use of all financial resources available to any one client.

TABLE 76

IF YES, WHAT AGENCY?

Agency	Number of cases	Percent
Department of Public Welfare	37	25.3%
Unemployment Compensation Commission	-	-
Industrial Accident Board	10	6.8%
Old Age Survivors Insurance	4	2.7%
Veterans Administration	9	6.2%
Other	24	16.4%
Blank	62	42.5%
TOTAL	146	100.0%

By far the most important agency which has expended funds on these cases was the Department of Public Welfare. This establishes that there should be very close and coordinated cooperation between the Division of Vocational Rehabilitation and the Department of Public Welfare. The large number of "other" and "blank" responses makes it difficult to assess the overall implications of interagency relationships.

TABLE 77

DOES THE CASE INDICATE AWARENESS AND UTILIZATION OF RELATED AGENCIES AND SERVICES? (BY THE COUNSELOR)

Answer	Number	Percent
Yes	96	65.8%
No	43	29.5%
Blank	7	4.1%
TOTAL	146	100.0%

COMMENTS:

The reviewers gave independent judgments for each case reviewed. This resulted in a divergence of opinion on some questions such as: "Reasons Not Serviced to Successful Conclusion," "Related Problems of Significance," and "Additional Services Needed." For this reason the answers of both interviewers are presented for those questions. In other categories of an objective nature, data is presented in one table. These variations, it should be noted, can be expected in any profession where individual judgment must be exercised and is, therefore, a reflection also of some of the processes that occur in counseling the disabled. Standardized evaluative procedures through a team process for certain difficult multiproblem clients would seem one method of assuring more complete and equitable rehabilitation services.

CHAPTER IX

RELATED PROGRAMS

Vocational Rehabilitation programs, and the processes that they utilize, reflect awareness that the individual often has problems of a multifaceted nature. The solution to these problems requires a wide variety of services, provided by many professionals and groups. Government has increasingly diverted large sums of money through numerous programs, old and new, in an attempt to alleviate the many pressing social and economic problems which beset a large segment of the population.

In planning to meet the needs of the disabled, it is necessary to consider the importance of the many public and private agencies that are an integral and vital part of comprehensive rehabilitation, as well as the effect their independent efforts have in meeting these needs.

The definition of disability is changing, and has not yet been clearly established. Recent legislation has broadened the term "handicapped" to include the psychosocial conditions. This ultimately will extend rehabilitation to those individuals who are culturally, educationally, and socially deprived.

The related programs referred to in this Chapter, then, offer many of the necessary services that can benefit the disabled of Montana. These agencies will increasingly become of concern to rehabilitation programs in the future.

The Aging

One in every 11 persons, or 9.4%, of those in the United States is age 65 or over. In Montana, as of 1965, 9.5% or 67,000 citizens are in this group, with an expectation that this number will increase to 82,000 by 1985.[1] Although fewer than one in five are in the labor force, the largest single source of total income is still earnings from employment. It is to this latter group, who may also have conditions of disability, that present rehabilitation programs can be directed. In Montana, recognition of the problems facing the senior citizen has resulted in the creation of the Montana Commission on Aging, which has dynamically promoted rehabilitation programs for senior citizens, particularly in cooperation with the Montana Department of Institutions.

In January of 1965, the Commission, in cooperation with the Administration on Aging, Department of Health, Education, and Welfare, undertook a Montana Senior Citizens Survey Investigation. Liaison was established between this group and Statewide Planning for Vocational Rehabilitation. As a result, rehabilitation related questions were included in the summary of this investigation.[2] This survey indicated that 13.8% of the respondents were interested in some type of employment. Of that group, 15% indicated a need to work because of the need for income. Major illnesses reported were:

Heart and cardiovascular - 19.0%
Rheumatism and arthritis - 14.4%
Other disabilities - 10.9%

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[1] Administration on Aging, Facts About Older Americans, United States Department of Health, Education, and Welfare, AOA Publication No. 410, May, 1966.

[2] Montana Commission on Aging, Montana Senior Citizens Survey, pp. 38-42, March, 1968.

Physical disabilities were:

Difficulty in walking - 10.1%
Visual problems - 5.2%
Auditory difficulties - 3.2%

A lesser number reported having other conditions. Of those reporting a physical impairment, 39.1% reported functional limitations.

Removal of barriers to accessibility of public places and buildings, through installation of escalators and elevators, was cited as important by 11.9%, and 4.6% felt steps should be removed. Installation of handrails, single floor activity placement, and the need for better public transportation were also mentioned by respondents.

The Community Survey of the Statewide Planning Project identified 769 disabled men and women, age 65 or over, who could now benefit from vocational rehabilitation services.

With the increase in the aging population in Montana, and the current need for rehabilitation services for the disabled senior citizen, special emphasis by the Division of Vocational Rehabilitation should be placed on programs for those able to benefit. No vocational rehabilitation program exists in Montana that applies to the senior citizen, by virtue of age alone, and little exists for the disabled oldster.

Correctional Rehabilitation

The programs available through the Division of Vocational Rehabilitation for delinquent youths and habitual criminals have been minimal in the past. Services have been extended to this group on the same basis as to other physically or emotionally disturbed individuals. In July of 1968, a unique project was formally initiated, as a cooperative effort of the Division of Vocational Rehabilitation, the Department of Institutions, and the State Forestry Department. This joint effort has resulted in the development of Swan River Youth Forest Camp, a work camp for delinquent youth. This facility will provide a full vocational rehabilitation program to those individuals. A Division of Vocational Rehabilitation counselor will be assigned to the Camp to provide counseling and all other necessary rehabilitation services.

Considerable interest has been expressed in vocational rehabilitation services and projects by Montana State Prison, Pine Hills School for boys, and Mountain View School for girls. Recommendations to initiate such services have been made to the Planning Project. The nationwide precedent established through the cooperative endeavor at the Swan River Youth Forest Camp is indicative of the direction that must be taken in Montana in order to serve those in the correctional institutions. Adequate diagnosis, treatment, vocational training, and placement is not yet available to the vast majority of the 729 inmates of Montana's correctional institutions.

Rehabilitation programs must be developed in the community, also, and Vocational Rehabilitation can provide effective services to those not yet requiring custodial treatment.

Economic Opportunity Program

There are currently 15 Community Action Programs in Montana, which provide services to the economically deprived citizen. These programs, designed at the community level to meet local needs, are therefore diverse in function and scope. Basic programs include vocational training, remedial education, work experience, employment, counseling, health-oriented activities, and family planning. Neighborhood Youth Corps, Job Corps, Headstart, Vista, Legal Aid, and Day Care Centers are not uniformly available to the economically deprived in Montana because of the local nature of the programs.

There exists a considerable opportunity for greater liaison between these programs and the rehabilitation agencies. The Statewide Planning Project received excellent response from the Community Action Program, which seems indicative of the potential for effective cooperative programming in the future. Communication between all programs should be of primary concern for all agencies.

Facilities and Workshops

The coordination and cooperation between the Workshops and Facilities Project of the Division of Vocational Rehabilitation and the Statewide Planning Project for Vocational Rehabilitation Services, was effected at an early stage. This coordination resulted in establishment of a joint committee whose deliberations and recommendations are expressed in this report.[3] This committee should be maintained and utilized by the Division of Vocational Rehabilitation and the Division of Blind Services as an on-going advisory committee.

Sub-Committee Activities

The Sub-Committee held four working meetings, three of which were of two-days' duration, and utilized nationally recognized consultants in the development of the Workshops and Facilities recommendations. In addition, the following facilities were visited in the state:

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[3] See Chapter VII, "Facilities."

Easter Seal Rehabilitation Center, Great Falls

Cascade County Convalescent Hospital, Great Falls

Butte Sheltered Workshop, Butte

Missoula Crippled Children's Rehabilitation Center, Missoula

Western Montana Youth Guidance Center, Missoula

Visits were made to the following out-of-state facilities:

Halfway Houses

Meeting House, Minneapolis

Wayside House, Inc., Minneapolis

House of Charity, Minneapolis

Nu-Way House, Minneapolis

House of Hope, Salt Lake City

Alcoholic Rehabilitation House, Salt Lake City

First Step House, Salt Lake City

DVR Rehabilitation Houses, Denver

Workshops

Goodwill Industries, Denver

Laradon Hall, Denver

Utility Workshop, Denver

Opportunity Workshop, Inc., Minneapolis

The committee is expected to carry on its function and to serve as an advisory group to the Division of Vocational Rehabilitation and the Division of Blind Services upon termination of the Statewide Planning Project.

Facilities of a Rehabilitation Nature Being Planned

1. Regional Comprehensive Mental Health Centers

   Status

   Region 1 - board organized, no personnel

   Region 2 - no activity

   Region 3 - no activity

   Region 4 - board being organized

   Region 5 - operative - no physical plant

2. Halfway Houses

   Status

   Great Falls Halfway House - initial development

   Billings - Halfway House for alcoholics - being organized, no personnel

   Billings - Halfway House for ex-convicts - initial planning

3. Rehabilitation Centers

   Status

   Missoula Crippled Children's Association - program operational in old facility; new facility designed and ready for bid letting

4. Sheltered Workshops

   Status

   Great Falls - planning grant application submitted

The Military Rejectee

Montana, in July of 1965, initiated a Health Referral Service for Military Rejectees as part of the program of the State Department of Health. The program provides counseling to those not accepted in the military because of medical or psychiatric rejection at the Armed Forces Examining Station in Butte. Appropriate referrals are made to private physicians, if desired by the rejectee, and also to community health and rehabilitation services. Approximately 3,709 men were examined for military induction between August of 1965 and March of 1966. Of these, 1,105 were rejected for health reasons, a rate somewhat below the national rate. Of these, 697 accepted counseling and follow-up services through Public Health Nurses in their home communities. The Division of Vocational Rehabilitation ranked second as the group to whom referrals were made, with the largest number being referred to family physicians for medical treatment.[4] The referral system is functioning very well for this disability group. The ten leading causes for rejection in 1965 and in the first three months of 1966 were:

1. Knee abnormalities
2. Obesity
3. Vision
4. Skin conditions
5. Asthma
6. Hernia
7. Hearing
8. Albuminuria
9. Heart conditions
10. Back conditions

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[4] _Montana Progress Report on Health Referrals and Counseling Program for Military Rejectees_, Treasure State Health.

Public Assistance

The Division of Blind Services, as an administrative unit of the Department of Public Welfare, has established a sound program of referral for services to visually impaired welfare recipients identified by local welfare departments. The Division of Vocational Rehabilitation has relied upon public assistance programs at the state and local levels as a referral source, as well as a resource for indigent rehabilitation clients. Public assistance recipients, at this time, must meet the basic eligibility criteria for Vocational Rehabilitation services.

A new program, the Work Incentive Program, is a cooperative endeavor of the Division of Vocational Rehabilitation, Montana State Employment Service, and the Department of Public Welfare. A working agreement has been entered into in an effort to return mothers receiving ADC (Aid to Dependent Children) to employment.

Title 19 or Medicaid, as it is referred to in Montana, is administered by the Department of Public Welfare. The Welfare Department has entered into a working relationship with the Division of Vocational Rehabilitation in order to provide needed services to mutual clients without duplication, and to strengthen the total program available to the welfare client.

The Rural Disabled

Montana is a predominantly rural state with a population density of 4.6 persons per square mile. Only two other states, excluding Alaska and Hawaii, are more sparsely populated. It is not unusual for disabled Montanans to drive 250 to 300 miles one-way within the state to receive necessary medical and rehabilitative services. In severe cases requiring intensive, long-term treatment of a medical or vocational nature, services can only be procured out-of-state in large population centers such as Seattle, Denver, or Minneapolis.

In Montana, the United States Department of Agriculture, Farmers Home Administration, through the 56 county extension offices serving the rural population, has developed County Technical Action Panels. These panels serve as a coordinating unit for all types of services to the rural population. The Statewide Planning Project early enlisted this organization as a resource for surveying the rural population for disability, and as a means of disseminating rehabilitation literature into rural communities.

The rural disabled have not received the services they require because of the general limitations of resources in Montana, and the problems inherent in delivery of quality services in sparsely populated regions.

The Technical Action Panels should be developed as a major resource for referrals to the Division of Vocational Rehabilitation. Programs that will provide quality services to rural residents should be undertaken immediately by all agencies. The establishment of facilities on a regional basis, as discussed in Chapter VII, should assure the availability of a wide spectrum of services to the rural disabled.

Rural workers in Montana are predominantly non-migratory. Rehabilitation services are extended without regard to residence, so those requiring such services can be assisted. Welfare residency requirements do, however, tend to exclude many of those who might benefit.

Social Security and Vocational Rehabilitation

In Montana, the Social Security Disability Determination Unit is administered by the Division of Vocational Rehabilitation. Referrals of potential clients for rehabilitation services are made on a regular basis. The referrals emanating from this source tend to be the most severely disabled, the older individuals, and frequently those less motivated to rehabilitation. In July of 1968, a special coordinator and a Division of Vocational Rehabilitation counselor were employed to work exclusively with these individuals to assure that services are extended rapidly and in depth. Social Security trust funds are utilized for this purpose. Social Security disability payment allowances in 1965 in Montana were made to 824 workers. Those who are denied, but show evidence of rehabilitation potential, are referred to the Division of Vocational Rehabilitation and the Division of Blind Services.

Workmen's Compensation

The three member Industrial Accident Board of Montana consists of the Commissioner of Labor and Industry, the Director of the Division of Vocational Rehabilitation, and one member appointed by the Governor. Presence of the Division of Vocational Rehabilitation Director on this Board provides very close liaison between the two agencies. The primary objective here is the referral of the disabled worker to Vocational Rehabilitation, as required by Section 92-1401, Revised Codes of Montana, 1947, as amended. An Industrial Accident rehabilitation account which assesses covered employers is administered by the Division of Vocational Rehabilitation for the purpose of providing services. Montana statutes provide a second injury law, Section 92-709A, Permanent and Total Disability Created by a Second Injury - Second Injury Account. This section applies to prior injuries of specific orthopedic and visual conditions. It does not include other conditions such as cardiac, respiratory, or other causes of limitations. Consideration should be given to include other conditions in this section.

The basic problems and the almost inevitable conflicts, which result when an individual is presented with a choice of cash benefits as compensation for an injury or rehabilitation, constitute a barrier to the rehabilitation of the industrially-injured worker. No satisfactory solution to this problem is in sight; therefore, total reassessment of the method of compensating the worker is indicated. Canadian practice, for example, views compensation as a pension which does not have an effect on rehabilitation. Consequently, the worker is compensated but also is able to participate fully in rehabilitation. Earlier and more frequent Division of Vocational Rehabilitation counselor contacts with referred workers is an immediate need.

Voluntary Organizations

There are many voluntary organizations in Montana with divergent programs which have varying degrees of application to rehabilitation of the disabled. Little cooperation exists among them in program planning. As a result, duplication of services and functions tends to occur, as it does in many of the public agencies. The Workshops and Facilities Sub-Committee of the Planning Project has demonstrated the value and feasibility of bringing together private agencies with similar and often conflicting interests into total rehabilitation planning. Such a federation, under the aegis of the public agencies who utilize private agency services, would substantially benefit all disabled.

Recommendations in Chapter VII of this report reflect this thinking. The information and referral service, felt to be essential by many practitioners throughout the state, can be developed through a full utilization of existing agencies, such as the Easter Seal Society and the Information and Referral Center in Great Falls, which is functional in a multi-county area. Cooperative, itinerant speech therapy programs of the Elks Lodge, Easter Seal, and School Districts established a precedent for further private and public cooperation.

Summer camps for disabled children are currently being sponsored by private groups, such as Easter Seal, Lions Club, and the Association for Retarded Children. Similarly, needed camps for other disability groups should be developed.

Private groups are frequently developed to pursue special interests in the field of rehabilitation, but these efforts are most often independent of any other group. It is vital in total planning that the tremendous enthusiasm and impetus provided by such interested groups be brought to bear in the coordinated total effort that must exemplify the rehabilitation movement in Montana. This can be effected without loss of individual program administration and integrity through development of the concepts entailed in the base-satellite approach.[5]

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[5] See Chapter III.

The Vocational Rehabilitation agencies become a logical nucleus for such coordinating efforts because of the legal responsibility vested in them. Also available to them are potentially substantial funds, and they are charged with using these monies in the most effective and economical manner, which implies the effective utilization of existing facilities and resources.

Recognition and appraisal of the strengths and weaknesses of both public and private agencies, with the ultimate goal of strengthening both, is necessary to a well-rounded comprehensive program.

Inter-Agency Coordination of Service Programs

Montana has traditionally had excellent working relationships among public agencies. This has been demonstrated and further developed by the Statewide Planning Project. The State Employment Service local offices have worked closely with the Division of Vocational Rehabilitation counselors, and have provided testing services and placement assistance to the disabled clients of the Division. Manpower Development Training Act trainees will have minor medical problems paid for, up to $100.00 per client, by the Division.

The state and local Welfare Departments have always worked with DVR and DBS in developing rehabilitation programs for the indigent disabled, and more recently have participated in joint staff training sessions.

Public Health has provided supplementary services to rehabilitation clients, and many mutual rehabilitation programs have been jointly developed. Other similar examples of agency cooperation can be cited.

The participation in district rehabilitation Planning Project meetings of local representatives of related public agencies was, in the majority of instances, outstanding. The sincere interest in the Project and in the disabled was further demonstrated by the tremendous time and effort that these agencies put forth in the completion of the Community Survey forms. The information gathered in the Project surveys has been provided to the State Cooperative Area Manpower Planning System (CAMPS) for utilization in the development of that plan.

Difficulty in coordination of the many new programs initiated by the federal government has demonstrated the need for a reassessment of existing administrative relationships, and the establishment of new working agreements where none now exist. The confusion of roles of new and existing agencies in the delivery of services must be resolved, either on a voluntary basis or through a realignment of the state administrative structure of all agencies under one central agency.

Coordination with Other State Planning

The coordination of service programs alluded to in the preceding section pertains to overall state planning activities as well.

The Montana Legislature established a State Department of Planning and Economic Development. The Governor has appointed a Federal-State Coordinator. The Department of Planning and Economic Development has been concerned primarily with industrial, rather than social service planning. The Statewide Planning Project for Vocational Rehabilitation Services was beyond the midway point of its operation prior to the functioning of the office of Federal-State Coordinator. The Director of the Division of Vocational Rehabilitation has served as liaison with that office, and has participated in the meetings called by the Federal-State Coordinator. In view of the temporary nature of the Vocational Rehabilitation Planning Project, this approach was felt to offer the best opportunity for continuing involvement of DVR in overall state planning.

The Mental Health Planning and Mental Retardation Planning activities were concluded prior to the beginning of this Project; however, staff of the prior projects were consulted by Statewide Planning and were involved in committee meetings.

The Hospital and Facilities Planning (Hill-Burton) staff was involved in the Project function having greatest relevancy to their interest; that is, the Workshop and Facilities Sub-Committee of this Project. The co-chairman of this Sub-Committee is the Director of the Medical Facilities Certification branch of the Department of Health. The Director of Hospital Facilities is a consultant to that Sub-Committee.

The adoption of the same five state regions by Statewide Planning for Vocational Rehabilitation Services which are used by the Mental Health, Mental Retardation, and Hospital Facilities should facilitate future planning and development.

Coordination with the Division of Vocational Rehabilitation's Workshop and Facilities Project has been complete from the inception of both projects through the utilization of the same committee, consultants, and the close cooperation of the two Project Directors.

Comprehensive Health Planning has become functional, and liaison is being established by the Director of the Division of Vocational Rehabilitation who sits as an ex-officio member of that group.

Coordination is acknowledged by all to be an absolute necessity if adequate and unduplicated programs are to be offered. The recommendations in this report are but a beginning in the resolution of this problem, which can be expected to become more complex as new programs are developed.

CHAPTER X

SUMMARY OF RECOMMENDATIONS

The following recommendations are presented with proposed time limits for implementation:

Immediate - 1970

Intermediate - 1972

Long Range - 1975

The agencies indicated are felt to have major responsibility for taking the initiative in implementation of the recommendation. They are identified as follows:

DVR - Division of Vocational Rehabilitation

DBS - Division of Blind Services

DPW - Department of Public Welfare

DPI - Department of Public Instruction

LEG - Legislature

SBH - State Board of Health

ES - Employment Service

MHA - Mental Health Authority

OEO - Office of Economic Opportunity

BI - Board of Institutions

MAR - Montana Association for Rehabilitation

PROGRAM ADMINISTRATION

IMMEDIATE

DVR
DBS
LEG
See P. 31

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES TAKE ADDITIONAL STEPS TO ASSURE THAT REHABILITATION SERVICES ARE AVAILABLE TO ALL DISABLED OF THE STATE, PARTICULARLY TO THOSE REQUIRING MORE INTENSIVE AND CONTINUOUS SERVICE. SPECIAL CONSIDERATION SHOULD BE GIVEN TO SERVICE FOR PERSONS IN THE STATE CUSTODIAL INSTITUTIONS. A REALISTIC COUNSELOR/CLIENT RATIO FOR EACH COUNSELOR IS NECESSARY.

IMMEDIATE

DVR
DBS
DPI
LEG
See P. 35

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION ADOPT AN OPERATIONAL POLICY WHICH WOULD EXTEND COUNSELING AND PRE-VOCATIONAL SERVICES TO SEVERELY DISABLED PERSONS WITHOUT REGARD TO A MINIMUM AGE, AND THAT THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES EXTEND VOCATIONAL SERVICES TO ALL DISABLED AS RAPIDLY AS RESOURCES PERMIT.

IMMEDIATE

LEG
See P. 44

PLANNING TO BE EFFECTIVE SHOULD BE BROAD IN SCOPE, FORMAL, AND CONTINUOUS. A PERMANENT COMMITTEE, BROADLY REPRESENTATIVE OF REHABILITATION INTERESTS, SHOULD BE APPOINTED FOR THE PURPOSE OF PROVIDING ADVICE, COUNSEL, AND SUPPORT TO THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES. THE COMMITTEE WOULD ALSO HAVE RESPONSIBILITY FOR REHABILITATION PLANNING ACTIVITIES AND FOR THE PROVISION OF INFORMATIONAL SERVICES THROUGH THE UTILIZATION OF A PROFESSIONAL PLANNING COORDINATOR.

IMMEDIATE

DVR
DBS
LEG
See P. 47

THERE IS A NEED FOR A FORMAL, ON-GOING PROGRAM OF INFORMATION AND EDUCATION BY THE DIVISION OF VOCATIONAL REHABILITATION AND THE DIVISION OF BLIND SERVICES. THIS PROGRAM WOULD SERVE TO BETTER INFORM THE DISABLED, THE PROFESSIONALS IN RELATED FIELDS, AND THE PUBLIC OF REHABILITATION SERVICES. IT WOULD CREATE AN AWARENESS OF THE PROBLEMS OF THE DISABLED AND ASSIST IN DEVELOPING AN ATMOSPHERE OF ACCEPTANCE OF THE DISABLED IN THEIR COMMUNITIES. THIS ACTIVITY COULD BE A FUNCTION OF A PERMANENT REHABILITATION COMMITTEE.

LEGISLATION

IMMEDIATE

LEG
See P. 39

APPROPRIATIONS SHOULD BE INCREASED AT THE STATE LEVEL TO ENABLE MONTANA TO RECEIVE THE MAXIMUM FEDERAL REHABILITATION MONIES NOW AVAILABLE, BUT UNUSED, SO THAT MORE DISABLED CAN BE ADEQUATELY SERVED.

INTERMEDIATE

DPI
LEG
See P. 95

ALL CHILDREN SHOULD ATTEND SCHOOL. IT IS RECOMMENDED THAT LEGISLATION BE ENACTED PROVIDING THAT LOCAL SCHOOL AUTHORITIES APPOINT THREE OR MORE PROFESSIONAL PERSONS TO DECIDE WHETHER OR NOT A HANDICAPPING CONDITION PREVENTS THE CHILD'S ATTENDANCE AT SCHOOL. THESE PERSONS SHOULD BE REPRESENTATIVES FROM MEDICINE, EDUCATION, AND THE SOCIAL SERVICE PROFESSIONS.

LONG RANGE

FED GOVT
DPW
See P. 114

RESIDENCY REQUIREMENTS, WHICH NOW EXIST FOR SERVICES IN STATE WELFARE DEPARTMENTS, CONSTITUTE A BARRIER TO THE EFFECTIVE REHABILITATION OF THOSE DISABLED WHO MUST CROSS STATE LINES TO RECEIVE NECESSARY TREATMENT AND TRAINING. IT IS RECOMMENDED THAT ACTION BE TAKEN TO REMOVE THESE REQUIREMENTS.

COORDINATION

IMMEDIATE

LEG
PRIVATE AND PUBLIC AGENCIES
See P. 65

THERE IS A NEED FOR CONTINUED AND STRENGTHENED COOPERATION AND COORDINATION AMONG AGENCIES TO PREVENT COSTLY DUPLICATION AND TO PROVIDE THE BEST POSSIBLE SERVICES AT A REASONABLE COST. IT IS THEREFORE RECOMMENDED THAT THOSE GOVERNMENTAL AGENCIES WHO PROVIDE SERVICES TO DISABLED PEOPLE TAKE THE NECESSARY STEPS TO INSURE THAT THIS COOPERATION EXISTS.

LONG RANGE

LEG
See P. 68

IN ORDER TO PROMOTE INTER-AGENCY COOPERATION AND COORDINATION AND TO IMPROVE THE DELIVERY OF SERVICES TO THOSE IN NEED, IT IS RECOMMENDED THAT AS OFFICE SPACE IS LEASED OR CONSTRUCTED IN MONTANA, PLANS BE MADE TO LOCATE ALL SOCIAL AND HEALTH AGENCIES WITHIN THE SAME BUILDING. THIS CLOSE PROXIMITY OF RELATED AGENCIES WOULD ALSO FACILITATE THE POOLING OF SPECIALIZED PERSONNEL WHO COULD FUNCTION FOR MORE THAN ONE AGENCY.

IMMEDIATE

DVR
DBS
BI
See P. 108

IT IS RECOMMENDED THAT EFFECTIVE WORKING RELATIONSHIPS BE DEVELOPED BETWEEN THE TWO STATE REHABILITATION AGENCIES, THE STATE CUSTODIAL INSTITUTIONS, AND AFTERCARE DIVISION OF THE DEPARTMENT OF INSTITUTIONS. JOINT STAFF MEETINGS ARE NECESSARY TO ESTABLISH WORKING AGREEMENTS, DEVELOP A COMMON PHILOSOPHY, AND TO PLAN EFFECTIVE REHABILITATION PROGRAMS FOR THOSE IN THE INSTITUTIONS AND DISCHARGEES INTO THE COMMUNITY.

IMMEDIATE

DVR
DBS
DPW
SBH
ES
See P. 112

IT IS RECOMMENDED THAT FREQUENT INTER-STAFF TRAINING PROGRAMS BE CONTINUED AND EXPANDED AT BOTH THE STATE AND LOCAL LEVEL AS A MEANS OF INSURING THAT COORDINATION BETWEEN THE DIVISION OF BLIND SERVICES, DEPARTMENT OF PUBLIC WELFARE, DIVISION OF

VOCATIONAL REHABILITATION, AND PUBLIC HEALTH PERSONNEL CONTINUES IN ITS CURRENT SATISFACTORY MANNER.

SPECIAL PROGRAMS

IMMEDIATE

SBH
PRIVATE GROUPS
See P. 62

THE IMMEDIATE DEVELOPMENT OF SPECIAL CLINICS AND CAMPS SHOULD BE UNDERTAKEN TO SERVE THE DISABLED CHILD IN THE PRE-TEENAGE GROUP. CHILDREN AFFLICTED WITH CONDITIONS SUCH AS DIABETES, EPILEPSY, MENTAL RETARDATION, BLINDNESS OR DEAFNESS REQUIRE SPECIAL ASSISTANCE IN PERSONAL AND SOCIAL ADJUSTMENT TO THE DISABILITY, IN ESTABLISHING AND MAINTAINING AN EFFECTIVE SELF-CARE PROGRAM, AND IN FOLLOWING A PROPER MEDICAL REGIMEN.

IMMEDIATE

DVR
DBS
See P. 73

IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION PLACE INCREASED EMPHASIS ON THE ROLE OF THE TOTAL FAMILY IN THE REHABILITATION PROGRAM OF THE DISABLED PERSON THROUGH THE PROVISION OF FAMILY COUNSELING. CONSIDERATION OF THE FAMILY, AS AN INFLUENTIAL FACTOR, WOULD OFTEN HELP TO INSURE A MORE SUCCESSFUL INDIVIDUAL REHABILITATION PLAN.

IMMEDIATE

SBH
DPW
DPI
MHA
See P. 82

EFFORTS AIMED AT THE PREVENTION OF DISABILITY AND HANDICAPPING CONDITIONS THROUGH EDUCATION, EARLY DETECTION, AND REFERRAL ARE ESSENTIAL ASPECTS OF REHABILITATION, AND NECESSARY STEPS MUST BE TAKEN TO INITIATE SUCH PROGRAMS.

IMMEDIATE

SBH
DPW
OEO
DPI
MHA
School Districts
See P. 86

IT IS RECOMMENDED THAT LOCAL SCHOOL DISTRICTS ESTABLISH NEW PROGRAMS, OR EXPAND EXISTING PROGRAMS, OF SPECIAL SERVICES AND CLASSES FOR CHILDREN WITH SIGNIFICANT PROBLEMS OF A PHYSICAL, EMOTIONAL, OR EDUCATIONAL NATURE.

IMMEDIATE LEG DPH OEO DPI MHA See P. 92	TO INSURE THAT ALL EXCEPTIONAL CHILDREN, REGARDLESS OF SCHOOL DISTRICT, HAVE EQUAL ACCESS TO SPECIAL TREATMENT AND EDUCATIONAL PROGRAMS, IT IS RECOMMENDED THAT A COMPREHENSIVE STUDY BE MADE OF EXISTING SCHOOL PROGRAMS, AND THAT STATE EFFORTS BE MADE TO CORRECT THE INEQUALITIES OF SERVICE AND OPPORTUNITY THAT CURRENTLY EXIST FOR SUCH CHILDREN.
IMMEDIATE DPI DVR LOCAL SCHOOL DISTRICTS See P. 99	THERE SHOULD BE AN INCREASE IN THE COOPERATIVE WORK-STUDY PROGRAMS FOR EXCEPTIONAL CHILDREN AT THE SECONDARY SCHOOL LEVEL. EXISTING PROGRAMS FOR THE MENTALLY RETARDED AND THE PHYSICALLY HANDICAPPED HAVE DEMONSTRATED THE VALUE OF THIS TRAINING AND ADJUSTMENT IN THE PLACEMENT OF YOUNG PEOPLE IN PRODUCTIVE POSITIONS IN THE COMMUNITY.
INTERMEDIATE BI DVR See P. 101	THE PERSON DISCHARGED FROM STATE CUSTODIAL INSTITUTIONS BACK TO COMMUNITY LIVING REQUIRES ADEQUATE SUPPORTIVE AND THERAPEUTIC SERVICES IF A SATISFACTORY ADJUSTMENT IS TO BE MADE. PROGRAMS PROVIDING SUCH SUPPORT, INCLUDING FAMILY COUNSELING, MUST BE DEVELOPED IN THE COMMUNITIES.
INTERMEDIATE BI DVR See P. 103	AFTERCARE SERVICES FOR YOUTHFUL PATIENTS RELEASED FROM WARM SPRINGS STATE HOSPITAL SHOULD BE PROVIDED ON THE SAME BASIS AS SERVICES NOW BEING PROVIDED OTHER INSTITUTION DISCHARGEES.
INTERMEDIATE BI DVR See P. 106	FOSTER HOME CARE OR OTHER TRANSITIONAL LIVING ARRANGEMENTS SHOULD BE CONSIDERED FOR THOSE DISCHARGEES FROM WARM SPRINGS STATE HOSPITAL WHO REQUIRE SUCH SERVICES AS A MEANS OF REINTEGRATION INTO THE COMMUNITY.

INTERMEDIATE

LEG
BOARD OF REGENTS
LOCAL SCHOOL DISTRICTS
See P. 110

VOCATIONAL TRAINING FACILITIES THAT WILL CONSIDER THE NEEDS OF DISABLED AND OTHER LIMITED PERSONS SHOULD BE PROVIDED IN MONTANA.

INTERMEDIATE

DVR
SBH
DBS
See P. 115

INDIVIDUALS WHO ARE REFERRED FOR REHABILITATION SERVICES ARE ACCEPTED OR REJECTED ON THE BASIS OF THE EXAMINING PHYSICIAN'S REPORT. THIS REPORT OFTEN REFLECTS THE EXAMINER'S INTERPRETATION OF THE RELATIONSHIP OF THE MEDICAL CONDITION TO A VOCATIONAL HANDICAP. IT IS RECOMMENDED THAT A STUDY BE MADE OF SUCH REJECTED CASES TO DETERMINE IF OTHER RELATED CONDITIONS CREATE PROBLEMS THAT REQUIRE ATTENTION.

IMMEDIATE

PRIVATE GROUPS
SERVICE CLUBS
See P. 119

THERE IS A NEED TO DEVELOP PROGRAMS OF ACTIVITIES FOR THE LEISURE TIME OF CERTAIN EMPLOYED INDIVIDUALS WHO REQUIRE STRUCTURED SOCIAL SITUATIONS. THE MENTALLY RETARDED ADULTS OR THOSE DISCHARGED FROM INSTITUTIONS, PLACED IN EMPLOYMENT IN THE COMMUNITY, OFTEN HAVE NEED FOR SUCH ACTIVITIES.

PERSONNEL

INTERMEDIATE

UNIVERSITY SYSTEM
See P. 70

IT IS RECOMMENDED THAT THE UNIVERSITY SYSTEM TAKE THE INITIATIVE IN TRAINING PERSONNEL TO MEET THE STAFF REQUIREMENTS OF THE MENTAL HEALTH FACILITIES, ALLIED PROFESSIONAL AGENCIES, AND PROFESSIONS IN THE REHABILITATION FIELD.

IMMEDIATE

SBH
DPI
OEO
MHA
See P. 89

IT IS RECOMMENDED THAT THE EMPLOYMENT OF, OR CONTRACTING FOR SERVICES OF, TRAINED PERSONNEL BE AN INTEGRAL PART OF PROGRAMS DEVELOPED IN THE SCHOOLS TO ASSIST THE EXCEPTIONAL CHILD IN

ORDER TO ASSURE THAT SUCH PROGRAMS ARE IMPLEMENTED AND DEVELOPED EFFECTIVELY.

IMMEDIATE LEG PUBLIC AND PRIVATE AGENCIES See P. 77	IT IS RECOMMENDED THAT WAGE SCHEDULES BE ESTABLISHED AT A LEVEL THAT WOULD INDUCE NEEDED PERSONNEL IN THE THERAPEUTIC AND SOCIAL SERVICE PROFESSIONS TO SEEK EMPLOYMENT IN MONTANA, AND WOULD RETAIN EXISTING PERSONNEL. THIS IS ESSENTIAL IF THE EXISTING AND ANTICIPATED NEEDS OF THE DISABLED ARE TO BE ADEQUATELY MET.
IMMEDIATE DVR DBS See P. 79	IT IS RECOMMENDED THAT INCREASED FUNDS BE MADE AVAILABLE BY BOTH THE STATE AND FEDERAL GOVERNMENT FOR IN-SERVICE TRAINING PROGRAMS AND SERVICES, BOTH IN AND OUT-OF-STATE, AND THAT THE DIVISION OF VOCATIONAL REHABILITATION ADOPT A PROGRAM WHICH PROVIDES FINANCIAL ASSISTANCE AND ENCOURAGEMENT TO PROFESSIONAL STAFF WHO WISH TO UPGRADE THEIR JOB SKILLS AND PROFICIENCY.
INTERMEDIATE SCHOOL DISTRICTS LOCAL AUTHORITIES See P. 105	LOCAL AND COUNTY AUTHORITIES SHOULD BE ENCOURAGED TO EMPLOY PUBLIC HEALTH NURSES AND OTHER TRAINED SOCIAL SERVICE PERSONNEL TO PROVIDE BETTER SERVICES TO DISABLED CHILDREN AND ADULTS IN THE COMMUNITIES.

REHABILITATION FACILITIES

INTERMEDIATE DVR DBS SBH PRIVATE AGENCIES See P. 243	ALL REHABILITATION FACILITY PLANNING IN MONTANA SHOULD CONSIDER THE NEED FOR INTERRELATED FACILITIES WITH SHARING OF RESOURCES, AND COMPLETE RECIPROCITY OF CLIENT REFERRALS.

LONG RANGE DVR DBS SBH PRIVATE AGENCIES UNIVERSITY SYSTEM See P. 248	A COMPREHENSIVE REHABILITATION CENTER SHOULD BE DEVELOPED IN MONTANA. IT SHOULD BE IN AN AREA WITH AN ADEQUATE MEDICAL COMMUNITY, SHOULD BE SUPPORTIVE OF TREATMENT CENTERS IN ACCORDANCE WITH THE BASE-SATELLITE CONCEPT, SHOULD SERVE MULTIPLE DISABILITIES, INCLUDING THOSE WHO ARE VISUALLY IMPAIRED, FROM ALL OVER THE STATE AND SURROUNDING AREAS, AND SHOULD FUNCTION IN COOPERATION WITH A UNIVERSITY.
INTERMEDIATE DVR PRIVATE AGENCIES See P. 254	IT IS RECOMMENDED THAT HALFWAY HOUSE FACILITIES BE DEVELOPED IN THE COMMUNITIES OF MONTANA FOR THOSE RELEASED FROM THE INSTITUTIONS WITH DISABILITIES OF MENTAL ILLNESS, PUBLIC OFFENSES, MENTAL RETARDATION, AND ALCOHOLISM.
IMMEDIATE DVR PRIVATE AGENCY See P. 254	TO DETERMINE THE FEASIBILITY OF A HALFWAY HOUSE SERVING MORE THAN ONE DISABILITY GROUP, IT IS RECOMMENDED THAT A JOINT DEMONSTRATION PROJECT BE UNDERTAKEN BY THE DIVISION OF VOCATIONAL REHABILITATION AND A PRIVATE AGENCY FOR THIS PURPOSE.
IMMEDIATE PRIVATE AGENCIES See P. 254	IT IS RECOMMENDED THAT COORDINATION BETWEEN PRIVATE GROUPS INTERESTED IN DIFFERENT DISABILITIES AND DEVELOPMENT OF FACILITIES TO SERVE THEM, BE ENCOURAGED FOR THE PURPOSE OF DELINEATING AREAS OF RESPONSIBILITY AND TO PROMOTE SHARING OF STAFF, IF FEASIBLE.
LONG RANGE DVR DBS PRIVATE See P. 258	MONTANA MUST DEVELOP MULTI-DISABILITY WORKSHOPS, TO INCLUDE THE VISUALLY HANDICAPPED, ON THE BASE-SATELLITE CONCEPT, AND FACILITIES SHOULD BE SO SITUATED AS TO BE READILY ACCESSIBLE TO THE DISABLED IN THE STATE. STANDARDS OF PROGRAMS SHOULD

CONFORM, WHENEVER POSSIBLE, WITH THOSE SUGGESTED BY THE NATIONAL INSTITUTE OF WORKSHOP STANDARDS, AS SET FORTH IN THE HANDBOOK OF THE NATIONAL ASSOCIATION OF SHELTERED WORKSHOPS AND HOMEBOUND PROGRAMS.

ARCHITECTURAL BARRIERS

INTERMEDIATE
LEG
See P. 120

EXISTING LEGISLATION RELATING TO THE ELIMINATION OF ARCHITECTURAL BARRIERS IN PUBLIC BUILDINGS (SECTIONS 69-3701 - 69-3719, REVISED CODES OF MONTANA, 1947) REQUIRES STRENGTHENING TO ASSURE COMPLIANCE WITH THE STANDARDS THAT HAVE BEEN ADOPTED.

IMMEDIATE
MAR
SERVICE GROUPS
See P. 122

A STATEWIDE BUILDING SURVEY SHOULD BE PLANNED AND CONDUCTED IN MONTANA TO ASSIST IN PLANNING FOR NEW STRUCTURES AND REMODELING OF EXISTING BUILDINGS TO MAKE THEM USABLE BY, AND ACCESSIBLE TO, THE HANDICAPPED.

CULTURALLY AND SOCIALLY DEPRIVED

INTERMEDIATE
DVR
See P. 58

IT IS RECOMMENDED THAT CONSIDERATION BE GIVEN TO THE EXTENSION OF REHABILITATION SERVICES AND PROGRAMS TO THOSE INDIVIDUALS WHO ARE UNABLE TO FUNCTION SOCIALLY, ECONOMICALLY, OR EDUCATIONALLY IN SOCIETY, IN THE SAME MANNER IN WHICH SERVICES HAVE BEEN EXTENDED TO THE PHYSICALLY HANDICAPPED, EMOTIONALLY DISTURBED, AND MENTALLY RETARDED INDIVIDUAL. SUCH PROGRAM MODIFICATION SHOULD BE ENCOURAGED AS RAPIDLY AS RESOURCES PERMIT.

EMPLOYMENT

INTERMEDIATE DVR DBS ES PERMANENT ADVISORY COMMITTEE See P. 53	A COMPREHENSIVE PROGRAM IS NEEDED TO ENCOURAGE THE EMPLOYMENT OF DISABLED WORKERS IN MONTANA'S BUSINESS AND INDUSTRY, BY ENLISTING THE SUPPORT OF EMPLOYERS, LABOR ORGANIZATIONS, SERVICE ORGANIZATIONS, THE CHAMBER OF COMMERCE, AND OTHER INTERESTED GROUPS.

STATE INSTITUTIONS

INTERMEDIATE BI DVR See P. 130	IT IS RECOMMENDED THAT A SHELTERED WORKSHOP FOR PATIENTS AT THE WARM SPRINGS STATE HOSPITAL BE DEVELOPED ON THE HOSPITAL GROUNDS, AND THAT THE INDUSTRIAL THERAPY PROGRAM BE INCREASED.
INTERMEDIATE DVR BI See P. 132	IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION PROVIDE SUFFICIENT COUNSELING STAFF TO FUNCTION WITHIN THE IN-PATIENT SERVICE OF THE WARM SPRINGS STATE HOSPITAL AND ALSO IN THE MENTAL HEALTH CENTERS AS THEY BECOME OPERATIVE.
IMMEDIATE DVR BI See P. 135	MORE COUNSELOR TIME SHOULD BE MADE AVAILABLE TO THE PATIENTS AT GALEN STATE HOSPITAL.
IMMEDIATE DVR BI See P. 139	A PART-TIME DIVISION OF VOCATIONAL REHABILITATION COUNSELOR SHOULD BE ASSIGNED TO WORK WITH THE MOUNTAIN VIEW SCHOOL.
IMMEDIATE DVR BI See P. 141	IT IS RECOMMENDED THAT A DIVISION OF VOCATIONAL REHABILITATION COUNSELOR BE PROVIDED THE MONTANA CHILDREN'S CENTER ON A REGULARLY SCHEDULED BASIS.

IMMEDIATE DVR BI See P. 143	IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION EMPLOY A STAFF PERSON WHO IS TRAINED IN CORRECTIONAL REHABILITATION TO WORK WITH INDIVIDUALS AND TO DEVELOP COOPERATIVE PROGRAMS AT MONTANA STATE PRISON.
IMMEDIATE BI DVR See P. 144	A STUDY SHOULD BE MADE OF THE NEED TO INITIATE A SPECIAL PROJECT TO DETERMINE THE REHABILITATION POSSIBILITIES OF THE INMATES OF MONTANA STATE PRISON.
IMMEDIATE DVR DBS BI See P. 145	IT IS RECOMMENDED THAT STEPS BE TAKEN TO ESTABLISH FUNCTIONAL RELATIONSHIPS BETWEEN THE DIVISION OF VOCATIONAL REHABILITATION, DIVISION OF BLIND SERVICES, AND THE STAFF OF MONTANA STATE PRISON.
IMMEDIATE DVR BI See P. 145	IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION INITIATE AND CARRY OUT REHABILITATION PROGRAMS WITH THE CORRECTIONAL INSTITUTIONS IN RECOGNITION OF THE PRESSING NEEDS OF THE INMATE POPULATION FOR SUCH SERVICES.
INTERMEDIATE DVR BI DPI See P. 148	VOCATIONAL TRAINING PROGRAMS SHOULD BE DEVELOPED AT THE PINE HILLS SCHOOL FOR BOYS.
IMMEDIATE DVR DBS BI See P. 151	IT IS RECOMMENDED THAT THE DIVISION OF VOCATIONAL REHABILITATION ASSIGN A COUNSELOR TO WORK AT THE BOULDER RIVER SCHOOL, AND THAT THE DIVISION OF BLIND SERVICES BE CONSIDERED FOR THOSE MEETING ELIGIBILITY REQUIREMENTS.

INTERMEDIATE DVR BI See P. 152	IT IS RECOMMENDED THAT A PLACEMENT UNIT BE INITIATED AT THE BOULDER RIVER SCHOOL TO DEVELOP PLACEMENT OPPORTUNITIES AND TO PROVIDE FOLLOW-UP TO DISCHARGEES IN THE COMMUNITY. SUCH A UNIT WOULD INCLUDE AN UPDATED INSTITUTIONAL TRAINING PROGRAM.
IMMEDIATE DVR DBS BI See P. 152	IT IS RECOMMENDED THAT EXPANSION BE MADE OF THE CURRENTLY SUCCESSFUL SUMMER PILOT PROGRAM OF THE DIVISION OF VOCATIONAL REHABILITATION, DIVISION OF BLIND SERVICES, AND THE BOULDER RIVER SCHOOL.
IMMEDIATE DVR See P. 153	THE DIVISION OF VOCATIONAL REHABILITATION SHOULD ENCOURAGE THE DEVELOPMENT OF HALFWAY HOUSES TO ENABLE MORE RETARDED TO BE PLACED WITHIN THE COMMUNITY.
IMMEDIATE DVR SCHOOL FOR THE DEAF & BLIND See P. 154	IT IS RECOMMENDED THAT A DIVISION OF VOCATIONAL REHABILITATION COUNSELOR, SKILLED IN WORKING WITH THE DEAF CLIENT, BE ASSIGNED TO THE SCHOOL FOR THE DEAF AND BLIND, AND THAT THIS COUNSELOR ALSO WORK WITH THE DEAF POPULATION OUTSIDE THE SCHOOL.
IMMEDIATE LEG See P. 155	IT IS RECOMMENDED THAT CONSIDERATION BE GIVEN TO CHANGING THE LAW WHICH DELINEATES THE RESPONSIBILITIES OF THE SUPERINTENDENT OF THE SCHOOL FOR THE DEAF AND BLIND. THE RESPONSIBILITY FOR SERVING AS PLACEMENT OFFICER AT THE SCHOOL, FOR COORDINATING A CENSUS OF DEAF AND BLIND CHILDREN, AND FOR FULFILLING OTHER DUTIES CANNOT BE ADEQUATELY MET WITHOUT ADDITIONAL FUNDS AND STAFF.

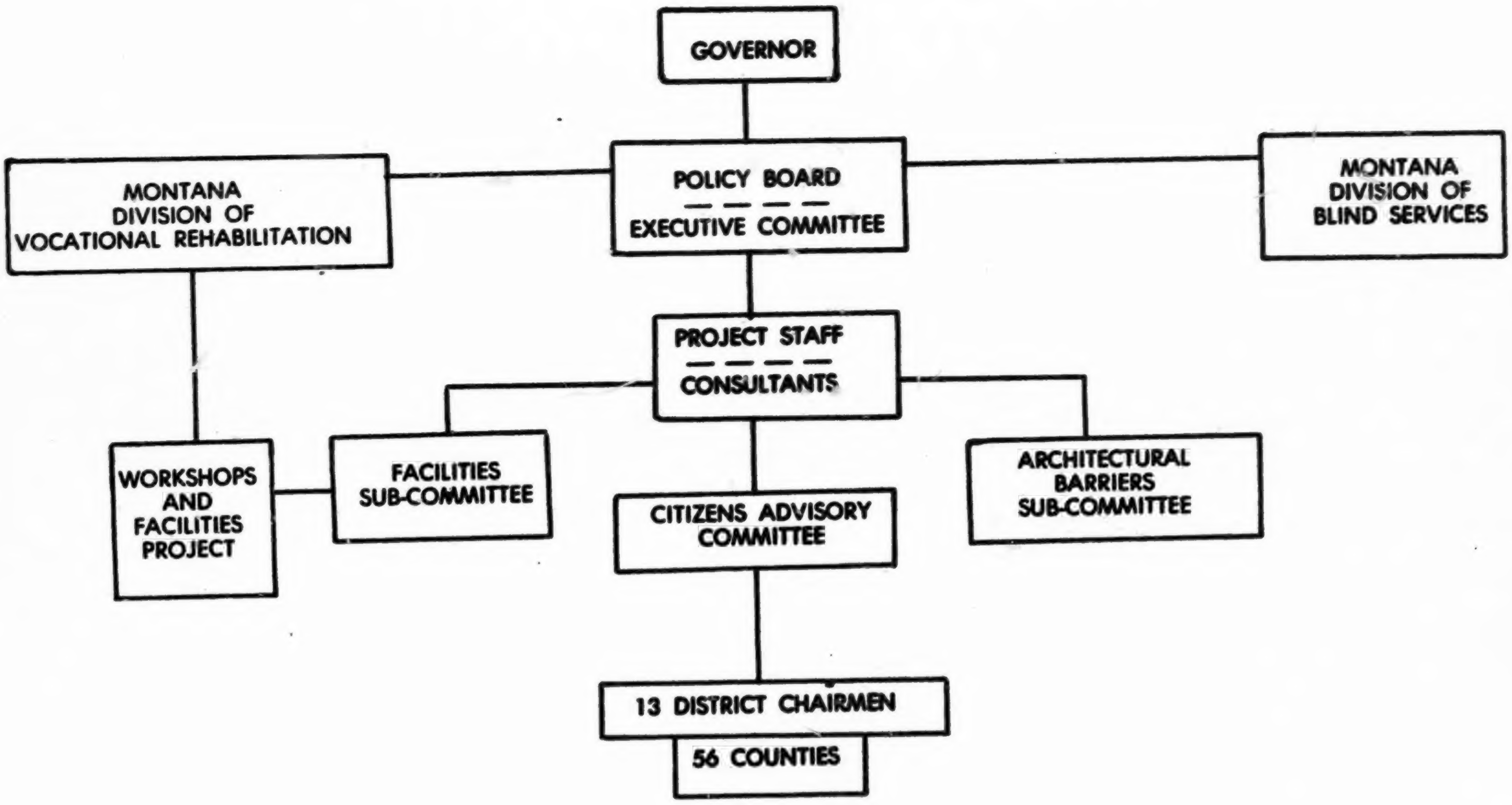
APPENDIX A

Organizational Charts

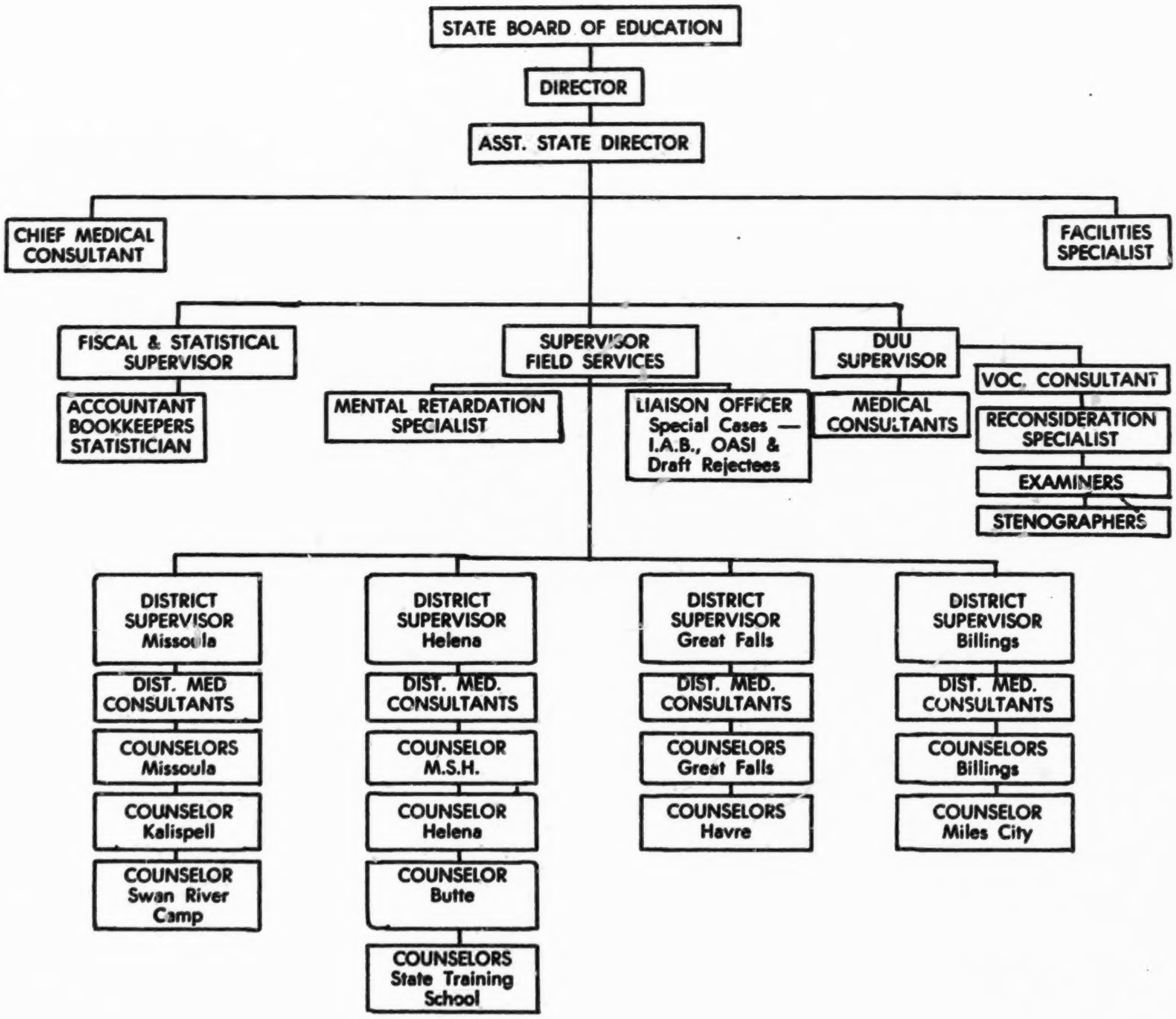
APPENDIX A

Organizational Charts

Statewide Planning

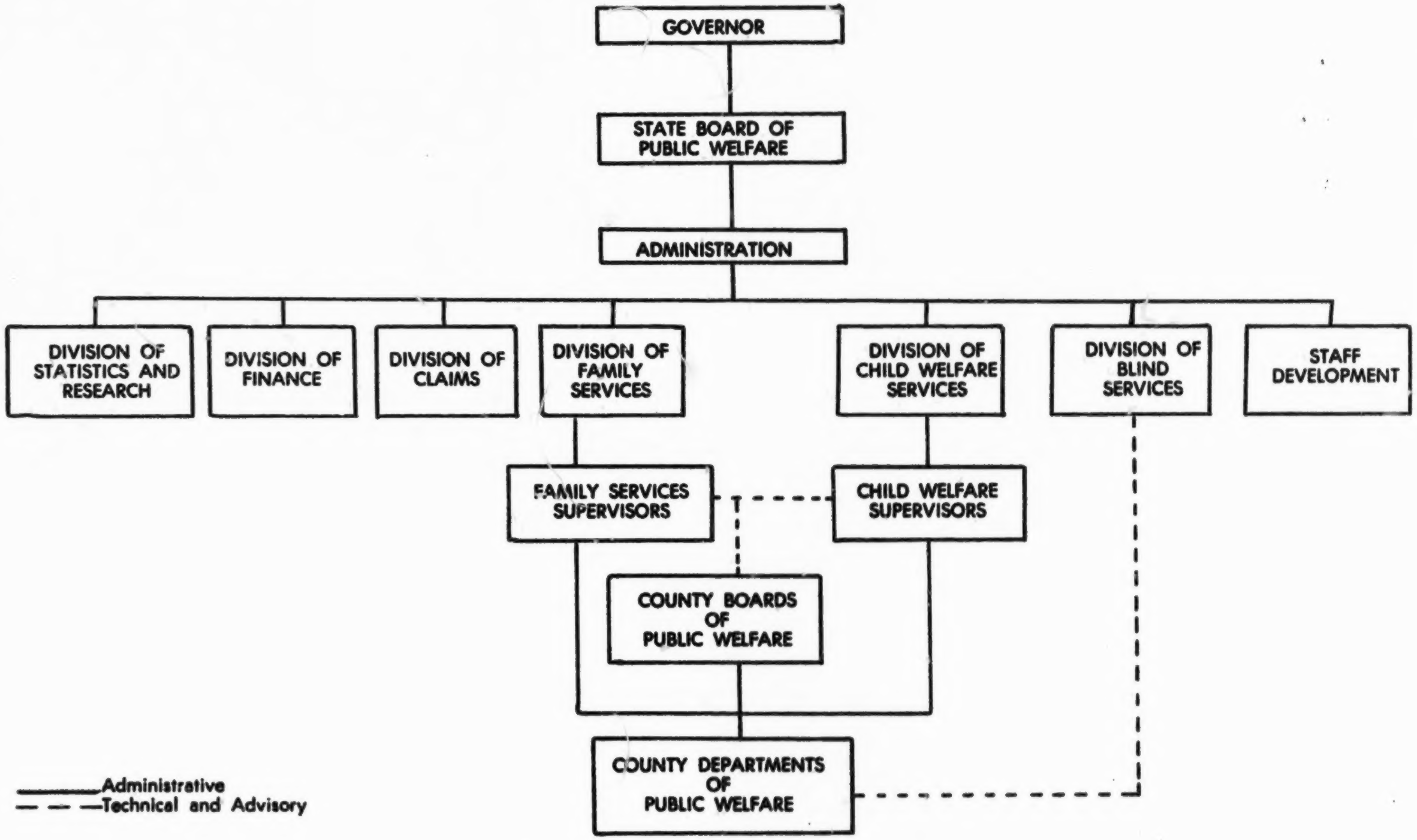

GOVERNOR
MONTANA DIVISION OF VOCATIONAL REHABILITATION
POLICY BOARD
EXECUTIVE COMMITTEE
MONTANA DIVISION OF BLIND SERVICES
PROJECT STAFF
CONSULTANTS
WORKSHOPS AND FACILITIES PROJECT
FACILITIES SUB-COMMITTEE
CITIZENS ADVISORY COMMITTEE
ARCHITECTURAL BARRIERS SUB-COMMITTEE
13 DISTRICT CHAIRMEN
56 COUNTIES

Division of Vocational Rehabilitation


STATE BOARD OF EDUCATION
DIRECTOR
ASST. STATE DIRECTOR
CHIEF MEDICAL CONSULTANT
FACILITIES SPECIALIST
FISCAL & STATISTICAL SUPERVISOR
ACCOUNTANT BOOKKEEPERS STATISTICIAN
SUPERVISOR FIELD SERVICES
MENTAL RETARDATION SPECIALIST
LIAISON OFFICER Special Cases — I.A.B., OASI & Draft Rejectees
DUU SUPERVISOR
MEDICAL CONSULTANTS
VOC. CONSULTANT
RECONSIDERATION SPECIALIST
EXAMINERS
STENOGRAPHERS
DISTRICT SUPERVISOR Missoula
DIST. MED CONSULTANTS
COUNSELORS Missoula
COUNSELOR Kalispell
COUNSELOR Swan River Camp
DISTRICT SUPERVISOR Helena
DIST. MED. CONSULTANTS
COUNSELOR M.S.H.
COUNSELOR Helena
COUNSELOR Butte
COUNSELORS State Training School
DISTRICT SUPERVISOR Great Falls
DIST. MED. CONSULTANTS
COUNSELORS Great Falls
COUNSELORS Havre
DISTRICT SUPERVISOR Billings
DIST. MED. CONSULTANTS
COUNSELORS Billings
COUNSELOR Miles City

Department of Public Welfare

Division of Blind Services


GOVERNOR
STATE BOARD OF PUBLIC WELFARE
ADMINISTRATION
DIVISION OF STATISTICS AND RESEARCH
DIVISION OF FINANCE
DIVISION OF CLAIMS
DIVISION OF FAMILY SERVICES
DIVISION OF CHILD WELFARE SERVICES
DIVISION OF BLIND SERVICES
STAFF DEVELOPMENT
FAMILY SERVICES SUPERVISORS
CHILD WELFARE SUPERVISORS
COUNTY BOARDS OF PUBLIC WELFARE
COUNTY DEPARTMENTS OF PUBLIC WELFARE
Administrative
Technical and Advisory

APPENDIX B

Project Organization

APPENDIX B

Governor's Policy Board

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Attorney at Law
Kalispell

John W. Strizich, M.D., Co-Chairman
Montana Medical Association
Helena

+Paul H. Babbitt, Special Education
Department of Public Instruction
Helena

**Rev. John W. Bauer
Catholic Charities
Helena

*Roger Bauer, Special Education
Department of Public Instruction
Helena

Roy Buffalo
Bureau of Indian Affairs
Billings

*Mrs. K. Elizabeth Burrell, Director
Health Education, Department of Health
Helena

**J. C. Carver, Director
Division of Vocational Rehabilitation
Helena

*Stephen Chiovaro, Superintendent
Boulder River School and Hospital
Boulder

Mrs. Elizabeth Diegel, Director
Clinical Nursing for MSU
Deaconess Hospital, Billings

+Carroll Donlevy
Bureau of Indian Affairs
Billings

*I. Wayne Eveland
Businessman
Helena

Emil Honka, Director
Division of Blind Services
Helena

Robert L. Miller, Supervisor
Special Applicant Service
Unemployment Compensation Commission
Helena

*Charles D. Parker, Ph.D., Director
Speech and Hearing Clinic
University of Montana, Missoula

+Miss Helen Raissle, Nursing Services
Veterans Administration, Helena

++Jack Womeldorf
Bureau of Indian Affairs
Billings

**T. J. Witham, Project Director
Statewide Planning Project
Helena

*Executive Committee Member

**Ex-Officio Member

+Resigned

++Deceased

Statewide Planning Project for Vocational Rehabilitation

Project Staff

T. J. Witham, Project Director

Mac Johnson, Project Analyst

*Jean Nelson, Project Secretary

Gloria D. Hauck, Project Secretary

Anne Wascisin, Clerk-Typist

*Resigned, January, 1967

Citizens Advisory Committee

Rev. John W. Bauer, Helena
Catholic Charities

H. A. Braun, M.D., Missoula
Montana Heart Association, Inc.

Herbert Carson, Missoula
Montana Association for Mental Health

Elmer Cochran, Helena
Alcoholics Anonymous

Mrs. R. H. Greger, Billings
American Legion Auxilary

Mrs. Doline Hardy, Laurel
Public Health Nursing Section

*Edwin Kellner, Helena
Montana Chamber of Commerce

Nicholas Kovick, Helena
Montana Education Association

William A. Macmillan, Helena
State Commission on Aging

James Meldrum, Helena
Montana Speech and Hearing Association

Joseph Meyer, Jr., Helena
Lutheran Social Services of Montana

R. A. Michels, Helena
Montana State Apprenticeship Council

Thomas A. McMaster, Helena
Montana Association for Retarded Children and Adults

Mrs. Norman W. Mills, Billings
National Foundation

James Murry, Helena
Montana AFL-CIO

Tony Persha, Red Lodge
Montana Association for the Blind

*Thomas Rimmer, Helena
Montana Tuberculosis Association

*O. K. Sather, Helena
American Cancer Society

Miss Frances Seyler, Helena
Montana Public Health Association

Del Siewert, Helena
Montana Chamber of Commerce

Rev. Warren P. Smith, Fort Benton
Montana Council of Churches

George Stocking, Great Falls
Montana Society for Crippled Children and Adults

David West, Butte
Montana Association for Physical Therapy

J. R. Wine, Helena
Montana Bar Association

Robert P. Yost, M.D., Missoula
Montana Heart Association, Inc.

Darwin C. Younggren, Great Falls
Montana Association for the Deaf

*Resigned

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District Chairman - William L. McClaren, Kalispell

Flathead	David Shanks, Kalispell
Lake	David McGuigan, Polson
Lincoln	Robert Jacky, Libby

District 2

District Chairman - Elmer Richey, Shelby

Glacier	Mrs. Aleen Spargur, Cut Bank
Pondera	Mrs. Arnold Lightner, Conrad
Toole	Dr. Lyle Iverson, Shelby

District 3

District Chairman - Mrs. Richard Vanderpool, Havre

Blaine	Mrs. R. G. Britmeier, Harlem
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Liberty	Belle Foster, Chester
	Mrs. Gary Jensen, Chester

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District Chairman - Alfred L. Olsen, Wolf Point

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Phillips	Mrs. Gladys Edwards, Malta
	Clara Lodmell, Malta
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District and County Chairmen (Continued)

District 6

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Judith Basin	William Schweigert, Stanford
Petroleum	Hugh Grove, Winnett
Wheatland	Lowell McGhie, Harlowton

District 7

District Chairmen - Mrs. Loretta Wirtala, Great Falls
Orvis Stenson, Great Falls

Cascade	Orvis Stenson, Great Falls
Chouteau	Dale Johnson, Fort Benton
Teton	Mrs. Carol Baker, Choteau

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District 11

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M. E. Evanson, Billings

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Carbon	Andrew Strickland, Red Lodge
Golden Valley	Lowell McGhie, Harlowton
Musselshell	Roy G. Fairley, Roundup
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Custer	Mrs. Edith Huntzicker, Miles City
Fallon	Walter Anderson, Ekalaka
Garfield	Charles Mahoney, Jordan
Powder River	Mrs. Ethel Bond, Terry
Rosebud	Charles A. Banderob, Lame Deer Vic East, Forsyth Norman Waterman, Forsyth

Facilities Sub-Committee

I. Wayne Eveland, Co-Chairman
Businessman
Helena

Ronald I. Williams, Staff Member
Facilities Specialist
Division of Vocational Rehabilitation
Helena

T. J. Witham, Staff Member
Project Director
Statewide Planning Project
Helena

S. C. Pratt, M.D., Co-Chairman
Department of Health
Helena

Sharon Cromeenes, Staff Member
Facilities Specialist
Division of Blind Services
Helena

Robert Munzenrider, Consultant
Department of Health
Helena

Membership

William McClaren, Dean of Students
Flathead Valley Community College
Kalispell (Region 1)

Mrs. H. W. Stoutenberg
Chairman of the Board and President
Missoula Crippled Children's Association
Missoula (Region 1)

Dr. W. L. Findley
Director, Special Education
Great Falls (Region 2)

George Stocking, Director
Easter Seal Rehabilitation Center
Great Falls (Region 2)

Lada J. Kafka
Senator and Rancher
Havre (Region 2)

Robert Kissell, Director
Butte Sheltered Workshop
Butte (Region 3)

Russell Steen, Administrator
Shodair Crippled Children's Hospital
Helena (Region 3)

Tony Persha, President
Montana Association for the Blind
Red Lodge (Region 4)

Mrs. Elizabeth O'Donnell
Director, Special Education
Billings (Region 4)

Dr. Robert Holmes, Chaplain
Rocky Mountain College
Billings (Region 4)

Mrs. Edith Huntzicker, Director
Department of Public Welfare
Miles City (Region 5)

Mrs. David Gregory
Housewife
Glasgow (Region 5)

Architectural Barriers Sub-Committee

Ralph Spitzer, Committee Chairman
Mountain States Telephone Company
Helena

Mac Johnson, Staff Member
Project Analyst
Statewide Planning Project
Helena

Membership

Phillip M. Auble
Mayor
Glendive

W. R. Donaldson
Supervisor of Field Services
Division of Vocational Rehabilitation
Helena

Lyle Downing, Executive Director
Commission on Aging
Helena

Stanley Gadach
General Services Administration
Helena

Philip H. Hauck, Director
Division of Architecture & Engineering
State of Montana
Helena

Lillian Jelstrup, Supervisor
Flathead County Welfare Department
Kalispell

Robert Kiesling
Montana Association for the Blind
Havre

Richard Mattson, Dean of Men
Northern Montana College
Havre

Rod Metzger
Missoula-Mineral Human Resources
Commission
Missoula

Jack Picard
Accountant
Anaconda

Thomas A. Selstad, Jr.
State Senator and Businessman
Great Falls

George Stocking, Executive Director
Easter Seal Rehabilitation Center
Great Falls

Mrs. Mona Sumner
Youth Guidance Council
Billings

James F. Watkins
Deputy Superintendent of Public
Instruction
Helena

Felix Webb, Vice-President
Midland National Bank
Billings

David West, Physical Therapist
Silver Bow General Hospital
Butte

Consultants

C. LeRoy Anderson, Ph.D.
Associate Professor of Sociology
Institute for Social Science Research
University of Montana
Missoula, Montana

Russell B. Haase, Supervisor
Rehabilitation House Program
Colorado Department of Rehabilitation
Denver, Colorado

R. G. Hampton, Executive Director
Opportunity Workshop of Lexington, Inc.
Lexington, Kentucky

Mervin J. Healy, Executive Director
Opportunity Workshop, Inc.
Minneapolis, Minnesota

William M. McPhee, Ph.D., Director
Regional Rehabilitation Research Institute
University of Utah
Salt Lake City, Utah

Mrs. Margaret Rudolph, Director
Granville House
St. Paul, Minnesota

Voyle C. Scurlock, Coordinator
Vocational Rehabilitation Management Training
University of Oklahoma
Norman, Oklahoma

John M. Self, Sr., Ph.D., Project Director
Vocational Rehabilitation Counselor Training
Eastern Montana College
Billings, Montana

Jack Stephens, Ph.D.
Sociology Department
Montana State University

APPENDIX C

Supportive Data

INDIVIDUAL DISABILITY FORM

State Planning for Vocational Rehabilitation

Code Number: ____________ (Use the first, middle and last initial of the individual.)

I. County or the individual's residence __________ (Use state license plate prefix) Example: Cascade County 2

II. Age
1. _____ 0-5
2. _____ 6-17
3. _____ 18-20
4. _____ 21-45
5. _____ 46-64
6. _____ 65 & Over

III. Marital Status
1. _____ Single
2. _____ Married
3. _____ Separated
4. _____ Divorced
5. _____ Spouse deceased

IV. Sex
1. _____ Male
2. _____ Female

V. Race
1. _____ Caucasian
2. _____ Indian (as considered)
3. _____ Negroid
4. _____ Mexican
5. _____ Other (specify) ________

VI. Employment Status
1. _____ Full time
2. _____ Generally full time
3. _____ Generally part time
4. _____ Seldom employed
5. _____ Never employed

VII. Do you feel that the disability you have identified presents a barrier to the full time employment and/or school performance of this individual?
1. _____ Definitely yes
2. _____ Possibly
3. _____ Uncertain
4. _____ Doubtful
5. _____ Definitely no

VIII. Disability Category (check each disability)
1. _____ Orthopedic
2. _____ Arthritis
3. _____ Visual impairments
4. _____ Amputations
5. _____ Hearing impairments
6. _____ Cardiac, heart and stroke
7. _____ TB and other respiratory
8. _____ Epilepsy
9. _____ Speech impairments
10. _____ Diabetes
11. _____ Alcoholism
12. _____ Drug addiction
13. _____ Mental illness
14. _____ Mental retardation
15. _____ Delinquency
16. _____ Habitual criminal
17. _____ Other (specify)__________

IX. To the best of your knowledge has the above individual ever been in contact with the Division of the Blind Services or the Office of Vocational Rehabilitation?
1. _____ Yes
2. _____ No

X. If the answer to the above question was yes, was the case
1. _____ Accepted
2. _____ Rejected
3. _____ Uncertain

XI. Agency completing this form
1. _____ Welfare
2. _____ Public Health
3. _____ Employment Service
4. _____ School
5. _____ Probation and/or parole
6. _____ Community action
7. _____ County Extension
8. _____ Other (specify) ________

If you would like to refer this case to the Division of the Blind Services or the Office of Vocational Rehabilitation please include the name of the individual __________________

PHYSICIAN QUESTIONNAIRE

RETURN TO: Department of Sociology
Montana State University
Bozeman, Montana

(Before August 21, 1967)

I. What is the nature of your practice:

Private
1. ______ General
2. ______ Special
Type of Specialty ______

Non-Private
1. ______ State
2. ______ Federal
3. ______ City or County
4. ______ Research and/or Teaching
5. ______ Other (specify) ________

II. How many physical, emotional, or socially handicapped patients have you referred to the Division of the Blind or Vocational Rehabilitation Agency in the last year?

1. ______ 0
2. ______ 1-3
3. ______ 4-6
4. ______ More than 6

III. What is your estimate of the success of these agencies in rehabilitating your patients back into the productive segment of society?

1. ______ Excellent
2. ______ Good
3. ______ Fair
4. ______ Poor
5. ______ Unable to Evaluate
6. ______ Other (specify) __________

IV. When one of your patients is referred to the Division of the Blind or Office of Vocational Rehabilitation (either by yourself or someone else), you as their doctor are asked to fill out a medical form relating to the nature of the handicap. (Not to be confused with Social Security Disability Determination form SSA-826).

a. Have you completed any of these forms in the last (2) two years?
______ Yes
______ No

b. If answer to IV (a) was "yes," do you feel the fee you received was:
______ Adequate
______ Inadequate
______ Other (specify) ____

c. Would you like to have the Agency inform you of their action in each individual case? Yes ________ No _________ Uncertain _________

d. Are you aware that your professional opinion is the major determinate in the action taken by the Office of Vocational Rehabilitation?

______ Yes
______ No

V. How many physically handicapped patients do you have that might benefit from service of a rehabilitative nature (who are not presently and have never been in contact with these agencies)? Please indicate the number in each diagnostic area.

1. ______ Orthopedic
2. ______ Arthritis
3. ______ Visual Impairments
4. ______ Amputations
5. ______ Hearing Impairments
6. ______ Cardiac, Heart, & Stroke
7. ______ TB & other respiratory
8. ______ Epilepsy
9. ______ Speech Impairments
10. ______ Diabetes
11. ______ Other (specify) ______

VI. a. Which of the following services of a rehabilitative nature are not available in your community?

1. ______ Physical Therapy
2. ______ Speech Therapy
3. ______ Audiology
4. ______ Occupational Therapy
5. ______ Psychologist
6. ______ Psychiatric Social Worker
7. ______ Medical Social Worker
8. ______ Vocational Evaluation
9. ______ Special Education Teachers for Handicapped
10. ______ Sheltered Workshop
11. ______ Halfway Houses
12. ______ Rehabilitation Center
13. ______ Treatment Center

b. Which of those checked immediately above would be most useful if made available in your community?

______, ______, & ______

c. Which would be the least useful? (Indicate by the number in the check list above)

______, ______, & ______

VII. Do you have any patients with emotional or social handicaps that might be more productive members of society if the above services were made available to them?

______ Yes
______ No (If yes, approximately how many?) ______

VIII. To what extent do you feel the following social handicaps are rehabilitatable?

	completely	partially	seldom	never	uncertain
Alcoholism					
Drug Addiction					
Mental Illness					
Mental Retardation					
Delinquency					
Habitual Criminality					

Do you feel that the Vocational Rehabilitation Agency in Montana should:

IX. 1. ______ Expand its services (operation)
2. ______ Maintain the status quo
3. ______ Reduce its services (operation)
4. ______ No recommendation

X. Comments ______________________________

____

MONTANA STATEWIDE PLANNING PROJECT
FOR VOCATIONAL REHABILITATION SERVICES

Professional Personnel Survey

(1-13) Profession (If employed in more than one position, check both)

1. ____ Administration
2. ____ Audiologist
3. ____ Adult Probation Officer
4. ____ Employment counselor
5. ____ High school counselor
6. ____ Juvenile probation officer
7. ____ Occupational therapist
8. ____ Physical therapist
9. ____ Psychologist
10. ____ Rehabilitation counselor
11. ____ Speech therapist
12. ____ Social worker
13. ____ Other (specify) ____________
____

Employment Status

(14)
1. ____ Full time
2. ____ Part time
3. ____ Not currently employed in your profession

(15)
1. ____ Salaried
2. ____ Hourly wage
3. ____ Consultant
4. ____ Volunteer

(16-21) If not currently employed in your profession, please check one or more of these reasons:

1. ____ Retired
2. ____ Family responsibilities
3. ____ Other employment
4. ____ Inadequate salary
5. ____ No jobs available
6. ____ Other (specify) ____________________

(22) If not currently employed in your profession, do you plan to return to it in the future?

1. ____ Yes
2. ____ No

Type of Agency

(23) Public

1. ____ Federal
2. ____ State
3. ____ County
4. ____ City
5. ____ School system

(24) Private

1. ____ National agency
2. ____ Local agency
3. ____ Private practice
4. ____ Other (specify) ____________
____

(25) How long have you been employed in your profession?

1. ____ Less than one year
2. ____ 1-3 years
3. ____ 4-6 years
4. ____ 7-9 years
5. ____ 10-12 years
6. ____ More than 12 years

(26) How long have you worked for your present agency?

1. ____ Less than one year
2. ____ 1-3 years
3. ____ 4-6 years
4. ____ 7-9 years
5. ____ 10-12 years
6. ____ More than 12 years

(27) How long have you been professionally employed in Montana?

1. ____ Less than one year
2. ____ 1-3 years
3. ____ 4-6 years
4. ____ 7-9 years
5. ____ 10-12 years
6. ____ More than 12 years

(28) Are you a native of Montana?

1. ____ Yes
2. ____ No

If no, please answer the following:

(29) What prompted you to accept employment in Montana?

1. ____ Attended college here
2. ____ Relatives or spouse were residents
3. ____ Recreational opportunities
4. ____ Opportunity for advancement
5. ____ Other (specify) ______________________________

(30-31) Your education has been principally in which one of these areas?

1. ____ Education
2. ____ Psychology
3. ____ Counseling and guidance
4. ____ Social work
5. ____ Rehabilitation
6. ____ Special education
7. ____ Business administration
8. ____ Occupational therapy
9. ____ Physical therapy
10. ____ Speech therapy
11. ____ Other (specify) ____________
____

(32) Level of education (check highest level completed)

1. ____ High school
2. ____ College, less than BA
3. ____ BA degree
4. ____ Some graduate work
5. ____ Masters degree
6. ____ Ph.D. or equivalent

(33) How much of the knowledge gained in classrooms is relevant to your position?

1. ____ Very little
2. ____ Some, not much
3. ____ Quite a bit, but learned more on the job
4. ____ More than any other source
5. ____ Almost all of it

(34) Are you allowed time to attend extension courses, conferences, etc., to further your professional skill?

1. ____ Yes
2. ____ No

(35) Does your agency have in-service training programs to further your professional skill?

1. ____ Yes
2. ____ No

(36-41) What incentives are provided by your agency for furthering your education? (check all that apply)

1. ____ Agency pays tuition only
2. ____ Agency pays books only
3. ____ Agency pays tuition and books
4. ____ Agency pays maintenance allowance while in training
5. ____ Better salary
6. ____ Better position

(42-54) Which of the following services do you or your agencies provide?

1. ____ Counseling
2. ____ Psychological evaluation
3. ____ Physical therapy
4. ____ Occupational therapy
5. ____ Vocational evaluation
6. ____ Vocational training
7. ____ Medical diagnosis
8. ____ Medical treatment
9. ____ Speech therapy
10. ____ Activities for daily living training
11. ____ Placement services
12. ____ Audiological services
13. ____ Other (specify) ____________________

(55) How much personal responsibility do you have for making decisions about cases?

1. ____ Complete responsibility
2. ____ Complete responsibility, some consultation with supervisor
3. ____ Some responsibility, some supervision
4. ____ Little responsibility, great amount of supervision
5. ____ Completely supervised

(56-66) What disability groups do you work with?

1. ____ Visual impairments
2. ____ Hearing impairments
3. ____ Orthopedic deformities
4. ____ Mental disorders
5. ____ Mental retardation
6. ____ Cancer
7. ____ Heart and circulatory
8. ____ Respiratory
9. ____ Speech
10. ____ Alcohol
11. ____ Other (specify) ____________________

(67-71) What are major age groups you work with?

1. ____ 0-6
2. ____ 6-18
3. ____ 18-45
4. ____ 45-65
5. ____ Over 65

(72) According to the standards of your profession, is your caseload:

1. ____ Below average
2. ____ Average
3. ____ Above average
4. ____ Excessive

(73) What percentage of your clients are out of work or restricted in work activity due to disabilities?

1. ____ 0-9
2. ____ 10-19
3. ____ 20-29
4. ____ 30-39
5. ____ 40-49
6. ____ 50 or over

(74-80) What are primary sources of referrals for your service?

1. ____ Self referral
2. ____ Physicians
3. ____ Public agencies
4. ____ Private agencies
5. ____ Schools
6. ____ Family
7. ____ Other (specify) ______ ____________________

Estimate the number of persons you have referred in past 12 months to:

(1) Div. of Vocational Rehabilitation

1. ____ None
2. ____ 1-5
3. ____ 6-10
4. ____ 11-20

(2) Division of Blind Services

1. ____ None
2. ____ 1-5
3. ____ 6-10
4. ____ 11-20

(3-8) If you seldom or never refer disabled clients to the above agencies, please indicate why:

1. ____ Ages below that accepted by DVR (currently 16 and over)
2. ____ Ages above labor market potential
3. ____ No suitable referral system
4. ____ Not familiar with above agencies
5. ____ Disabilities encountered do not present barrier to employment
6. ____ Other (specify) ________________________________

(9) If you have referred clients to above agencies, what is your estimate of success?

1. ____ Good
2. ____ Fair
3. ____ Poor
4. ____ Don't know

(10-17) Assuming availability of the following services, which would be of benefit to your clients:

1. ____ Individual rehabilitation counseling
2. ____ Group counseling
3. ____ Psychological testing
4. ____ Vocational training
5. ____ Psychiatric treatment
6. ____ Job placement
7. ____ Parental or family counseling
8. ____ Other (specify) ____

(18-21) If you are aware of disabled people who are not receiving services, what do you believe are the reasons?

1. ____ Lack of knowledge or information of available services
2. ____ Cost of effort necessary to get services
3. ____ Services inadequate or not available within geographic area
4. ____ Apathy on part of client or family

(22-30) If you would like additional information on the following related services, please indicate:

1. ____ Division of Vocational Rehabilitation
2. ____ Division of the Blind
3. ____ Physical therapy
4. ____ Occupational therapy
5. ____ Recreational therapy
6. ____ Speech therapy
7. ____ Audiology
8. ____ Psychiatric social work
9. ____ Prosthetics

(31-34) What methods of information would you prefer?

1. ____ Literature
2. ____ Personal call by counselor
3. ____ Local information programs
4. ____ State meetings

Comments: ____

____

____

Envelope is enclosed for return to:
517 Power Block
Helena, Montana 59601

MONTANA STATEWIDE PLANNING PROJECT
FOR VOCATIONAL REHABILITATION SERVICES

Survey of Professional Nurses

Name ____

Address ______________________________________

(1) Classification

1. ____ Registered
2. ____ Licensed practical

(2) Employment status

1. ____ Full time
2. ____ Part time
3. ____ Not currently employed in your profession

(3-8) If not currently employed in your profession, please check one or more of the following reasons:

1. ____ Retired
2. ____ Family responsibilities
3. ____ Other employment
4. ____ Inadequate salary
5. ____ No jobs available
6. ____ Other (specify) ______________________

(9) If not currently employed as a nurse, do you plan to return to nursing?

1. ____ Yes
2. ____ No

(10) Type of practice

1. ____ Private
2. ____ Doctor's or dentist's office
3. ____ Hospital
4. ____ Nursing home
5. ____ Public health
6. ____ Other (specify) ______________________

Type of agency

(11) Public

1. ____ Federal
2. ____ State
3. ____ City - County

(12) Private

1. ____ National
2. ____ Local

(13) Classification

1. ____ Salaried
2. ____ Hourly wage
3. ____ Consultant
4. ____ Volunteer

(14) How long have you been employed in your profession?

1. ____ Less than one year
2. ____ 1-3 years
3. ____ 4-6 years
4. ____ 7-9 years
5. ____ 10-12 years
6. ____ More than 12 years

(15) How long have you worked for your present agency?

1. ____ Less than one year
2. ____ 1-3 years
3. ____ 4-6 years
4. ____ 7-9 years
5. ____ 10-12 years
6. ____ More than 12 years

(16) How long have you been professionally employed in Montana?

1. ____ Less than one year
2. ____ 1-3 years
3. ____ 4-6 years
4. ____ 7-9 years
5. ____ 10-12 years
6. ____ More than 12 years

(17) Are you a native of Montana?

1. ____ Yes
2. ____ No

If no, please answer the following:

(18) What prompted you to accept employment in Montana?

1. ____ Attended school here
2. ____ Relatives or spouse were residents
3. ____ Recreational opportunities
4. ____ Opportunity for advancement
5. ____ Other (specify) ________________________________

(19) Level of education

1. ____ High school
2. ____ College or nurses training, less than BA
3. ____ BA degree
4. ____ Some graduate work
5. ____ Masters degree
6. ____ Ph.D. or equivalent

Are you allowed time to attend extension courses, conferences, etc., to further your professional skill?

(20) 1. ____ Yes
2. ____ No

(21) If yes, 1. ____ With pay
2. ____ Without pay

(22) Does your agency have in-service training programs to further your professional skill?

1. ____ Yes
2. ____ No

(23-35) Which of the following services are available in your community?

1. ____ Counseling
2. ____ Psychological evaluation
3. ____ Physical therapy
4. ____ Occupational therapy
5. ____ Vocational evaluation
6. ____ Vocational training
7. ____ Medical diagnosis
8. ____ Medical treatment
9. ____ Speech therapy
10. ____ Activities for daily living training
11. ____ Placement services
12. ____ Audiological services
13. ____ Other (specify) ________________________________

Estimate number of persons you have referred in past 12 months to:

(36) Div. of Vocational Rehabilitation

1. ____ None
2. ____ 1-5
3. ____ 6-10
4. ____ 11-20

(37) Division of Blind Services

1. ____ None
2. ____ 1-5
3. ____ 6-10
4. ____ 11-20

(38-43) If you seldom or never refer disabled clients to the above agencies, please indicate why:

1. ____ Ages below that accepted by DVR (currently 16 years)
2. ____ Ages above labor market potential
3. ____ No suitable referral system
4. ____ Not familiar with above agencies
5. ____ Disabilities encountered do not present barrier to employment
6. ____ Other (specify) ________________________________

(44) If you have referred clients to above agencies, what is your estimate of success?

1. ____ Good
2. ____ Fair
3. ____ Poor
4. ____ Don't know

(45) Please estimate how many of the patients you worked with in the past year could have benefited from services of DVR or Services for Blind:

1. ____ None
2. ____ 1-5
3. ____ 6-10
4. ____ 10-20
5. ____ Over 20

(46-52) Assuming availability of the following services, which would be of benefit to your patients?

1. ____ Individual rehabilitation counseling
2. ____ Group counseling
3. ____ Psychological testing
4. ____ Vocational training
5. ____ Psychiatric treatment
6. ____ Job placement
7. ____ Other (specify) ______________________________

(53-56) If you are aware of disabled people who are not receiving services, what do you believe are the reasons?

1. ____ Lack of knowledge or information of available services
2. ____ Cost of effort necessary to get services
3. ____ Services inadequate or not available within geographic area
4. ____ Apathy on part of patient or family

(57-65) If you would like additional information on the following related services, please indicate:

1. ____ Div. of Vocational Rehabilitation
2. ____ Division of Blind
3. ____ Physical therapy
4. ____ Occupational therapy
5. ____ Recreational therapy
6. ____ Speech therapy
7. ____ Audiology
8. ____ Psychiatric social work
9. ____ Prosthetics

(66-69) What methods of information would you prefer?

1. ____ Literature
2. ____ Personal call by counselors
3. ____ Local information programs
4. ____ State meetings

Comments: ______________________________

____

____

____

STATEWIDE PLANNING FOR VOCATIONAL REHABILITATION

Institutional Survey Form

Institution Name ____

Policies

A. Admission Procedures:

1. ______ Court commitment
2. ______ Physician referral
3. ______ Agency referral
4. ______ Family referral
5. ______ Voluntary
6. ______ Other (specify) ___
____
____
____

B. Patient types:

1. Age range _____ to ______

2. Disabilities -- Specify: ______________________________
____
____

[illegible] ______
b Deaf ______

C. Intake services:

1. ______ Medical exam
2. ______ Dental exam
3. ______ Social service
4. ______ Psychological testing
5. ______ Counseling
6. ______ Other (specify) ____
____
____

D. Programs:

1. ______ Treatment
2. ______ Group therapy
3. ______ Basic education
4. ______ Vocational training
5. ______ Work program
6. ______ Other (specify) ____
____
____

Staff

	Certified or Licensed (Number)	Unlicensed (Number)	Positions Budgeted Unfilled	Projected Need Next 10 yrs.
1. Physicians				
2. Therapists				
Physical				
Occupational				
Speech				
Industrial				
Recreational				
3. Nurses				
RN				
LPN				
Aids				
4. Attendants				
5. Teachers				
Academic				
Vocational				
6. Psychiatrists				
7. Psychologists				
8. Social workers				
9. Counselors				
10. Other (specify)				

Other Personnel

Type ______________________________ Hours per week __________

Inservice Training

Do you have an in-service training program? Yes _____ No _____

What method do you use for compensating employees who upgrade skills?

____

____

Patient Population

Current patient load ____________

Estimate patient load 1970 ____________ 1975 ____________

Changes in population over past 5 years ____________________

____

Followup on discharged patients

1. _____ Assigned staff

2. _____ Use of other agencies

3. _____ None

Do services of the Division of Vocational Rehabilitation adequately meet the needs of your patients? Yes ________ No ________

Do services of the Division of Blind Services adequately meet the needs of your patients? Yes ________ No ________

If the answer to either of the previous questions is no, please comment on improvements you would recommend. ____________________

____

____

What out-of-institution services do you feel would help you in narrowing the gap between institutional and community living for your patients upon discharge?

____

____

____
Date

____
Name of person completing form

____
Position

MONTANA STATEWIDE PLANNING PROJECT
FOR VOCATIONAL REHABILITATION SERVICES

CLOSED CASELOAD STUDY

Name ________________________________ Status ______ Evaluator _________

(1) Sex: ______ M ______ F (2) Residence: ______ Urban ______ Rural

(3) Age at closure: ______ 60 & over ______ 40-49 ______ 20-29 ______ Under 16

______ 50-59 ______ 30-39 ______ 16-19 ______ Unknown

(4) Number of dependents: ______ 1 ______ 3-4 ______ Over 6

______ 2 ______ 5-6 ______ Unknown

(5) Education: ______ Under 6th ______ 9-11 ______ Some College ______ BA

______ 6-8 ______ H.S. Diploma ______ 2 yrs college ______Unknown

Disability Category:

(6) ____ Orthopedic
(7) ____ Arthritis
(8) ____ Visual Impairments
(9) ____ Amputations
(10) ____ Hearing Impairments
(11) ____ Cardiac, heart, and stroke
(12) ____ TB and other respiratory
(13) ____ Epilepsy
(14) ____ Speech Impairments
(15) ____ Diabetes
(16) ____ Alcoholism
(17) ____ Drug addiction
(18) ____ Mental illness
(19) ____ Mental retardation
(20) ____ Delinquency
(21) ____ Habitual criminal
(22) ____ Other (specify) _________
____

Reasons not serviced to successful conclusion: (according to counselor)

(23) 1. Client disinterested:

a. ____ Change in circumstances (social, economic, mental, and medical)
b. ____ Awaiting outcome of insurance, OASI, etc.
c. ____ Other (specify) ______________________________________

(24) 2. ____ Client moved

(25) 3. ____ Client deceased

(26) 4. ____ Disability too severe

(27) a. Substantiated by medical evidence: ____ Yes ____ No

(28) 5. ____ Multiple disability

(29) 6. ____ Disability combined with age

(30) 7. ____ Client or family too migratory

(31) 8. ____ Client or family not financially able to assist in plan

(32) 9. ____ Alcoholism

(33) 10. ____ Antisocial behavior

(34) 11. ____ Lack of interest on part of client's family

(35) 12. ____ Other (specify) ________________________________

RELATED PROBLEMS OF SIGNIFICANCE IN CASE

(36) 1. ____ Age

(37) 2. ____ Migratory

(38) 3. ____ Antisocial behavior

(39) 4. ____ Lack of interest by client

(40) 5. ____ Lack of interest by family

(41) 6. ____ Multiple disabilities

(42) 7. ____ Lack of finances - client

(43) 8. ____ Lack of finances - agency

(44) 9. ____ Other (specify) ________________________________

(45) Do you think this client could have been rehabilitated if unlimited rehabilitation resources and funds were available to him? ____ Yes ____ No ____ Don't know ____ Can't determine on basis of data.

If answer is yes, check additional services that were needed:

(46) ____ General medical supervision

(47) ____ Special medical supervision

(48) ____ Rehabilitation nursing

(49) ____ Physical therapy

(50) ____ Occupational therapy

(51) ____ Prosthetic and orthotic services

(52) ____ Speech and audiology services

(53) ____ Laboratory and x-ray

(54) ____ Room and board

(55) ____ Infirmary care

(56) ____ Dental services

(57) ____ Counseling

(58) ____ Psychiatric treatment

(59) ____ Psychological testing

(60) ____ Vocational evaluation

(61) ____ Social casework

(62) ____ Family counseling and guidance

(63) ____ Activity of daily living therapy

(64) ____ Supervised recreational and social activities

(65) ____ Special academic instructions

(66) ____ Vocational training for limited, sheltered part-time employment

(67) ____ Vocational training for full-time competitive employment

(68) ____ Halfway house

(69) ____ Other (specify) ____

(70) ____ Do you agree with the counselor's reasoning used in closing this case?

____ Yes ____ No

(71) How much money was expended by DVR? (write in actual amount)

____ 0-24 ____ 50-99 ____ 250-499 ____ over 1,000

____ 25-49 ____ 100-249 ____ 500-1,000

(72) Is there indication that other agencies expanded funds? ____ Yes ____ No

(73) If yes, what agency? ____ DPW ____ UCC ____ IAB ____ OASI

____ VA __________________________ Other

(74) Does the case indicate awareness and utilization of related agencies and services? ____ Yes ____ No

Comments: ____

____

____

GUIDELINES FOR POLICY BOARD-AGENCY HEAD MEETING

MONTANA STATEWIDE PLANNING PROJECT FOR VOCATIONAL REHABILITATION SERVICES

With the objective of providing the best service possible to the disabled population of Montana, we would like your opinion on the following questions. If your reply does not pertain to both the Division of Vocational Rehabilitation and Division of Services for the Blind, please indicate the specific agency.

1. What do you feel the Vocational Rehabilitation Divisions can do to more effectively serve those disabled known to your agency?
2. What gaps in complete rehabilitative services do you know to exist?
3. Do you feel the relationship of your agency and the two rehabilitation agencies could be improved upon, particularly at the operational level? If you feel improvements can be made, please indicate the particular area to be developed, and any ideas you have that would enhance effective working relationships.
4. What plans does your agency have for developing or expanding the rehabilitative services that you now provide?
5. Your comments as to how your agency and the two rehabilitation divisions can best coordinate in planning for improvement in services and facilities to benefit the handicapped would be most helpful.
6. Please feel free to comment on any subject that could result in more effective services to the disabled.

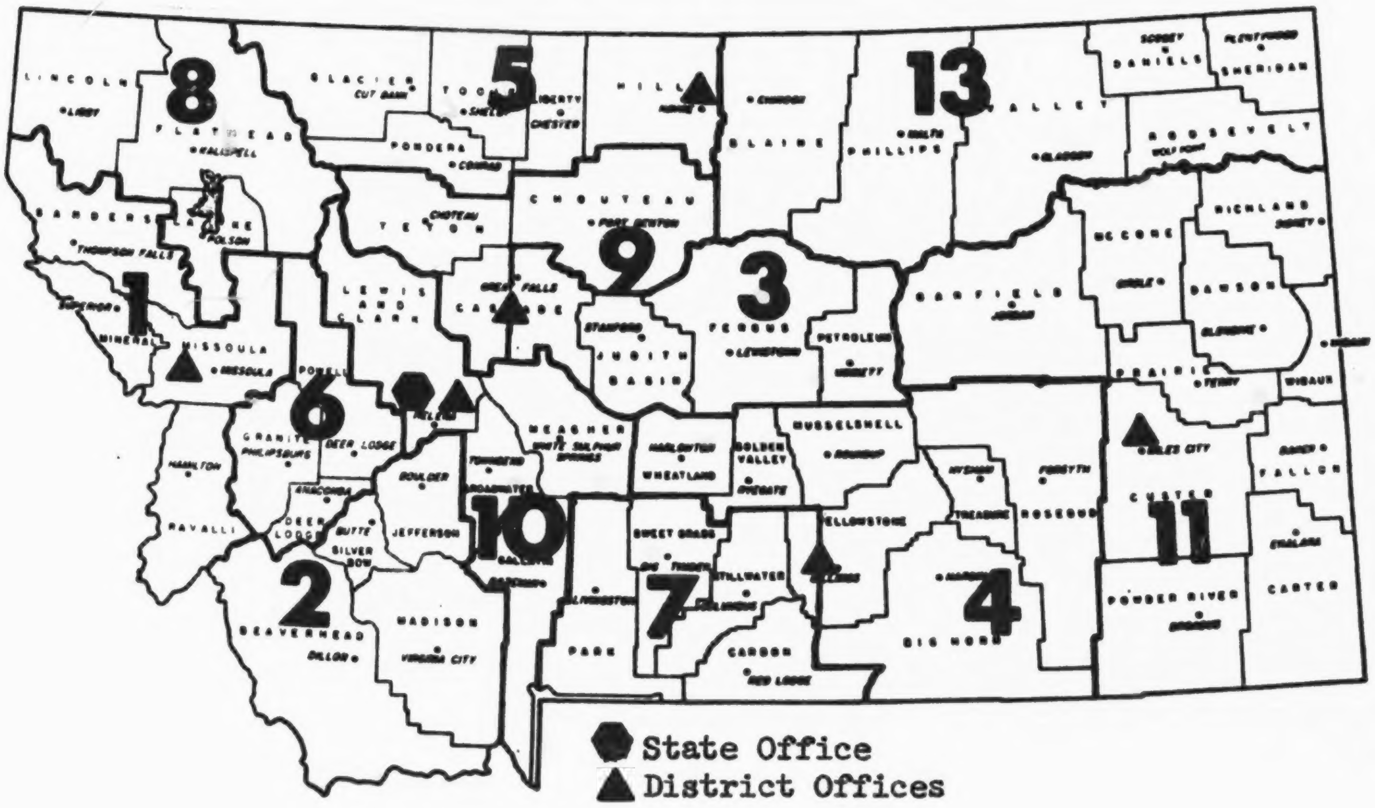
APPENDIX D

MAPS

APPENDIX D

Maps

MAP 8. DIVISION OF VOCATIONAL REHABILITATION OFFICES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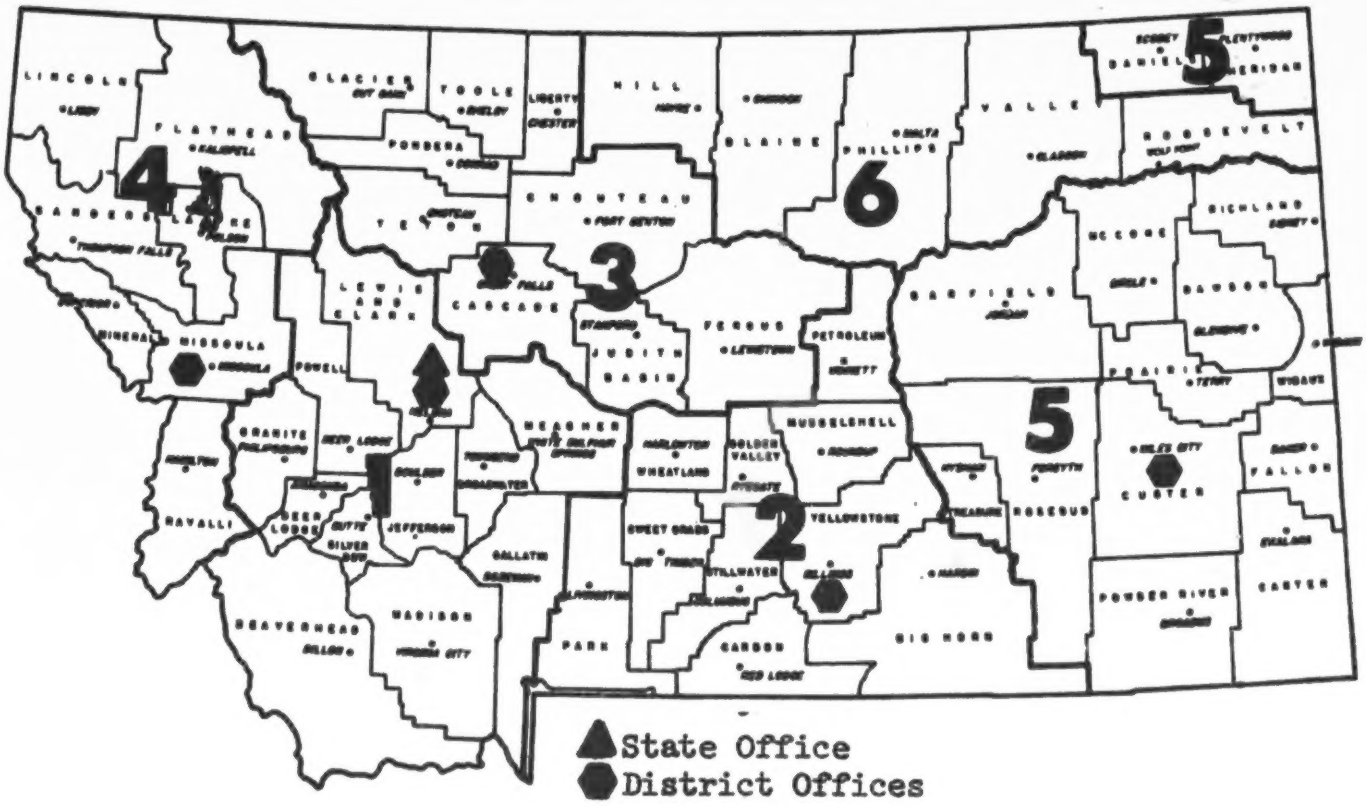
SWEET GRASS
STILLWATER
YELLOWSTONE
TREASURE
CARTER
BEAVERHEAD
MADISON
PARK
CARBON
BIG HORN
POWDER RIVER
● State Office
▲ District Offices

MAP 9. DIVISION OF BLIND SERVICES OFFICES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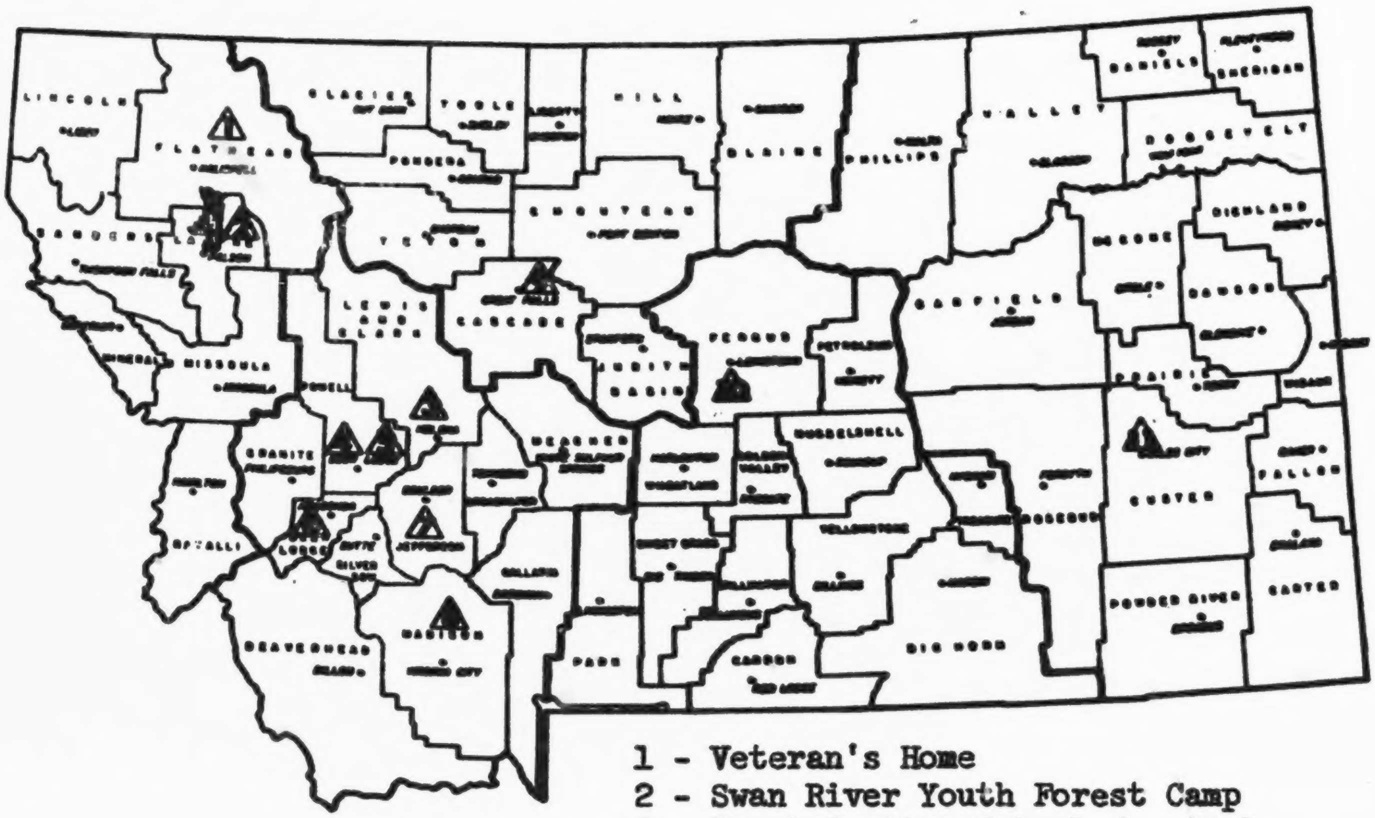
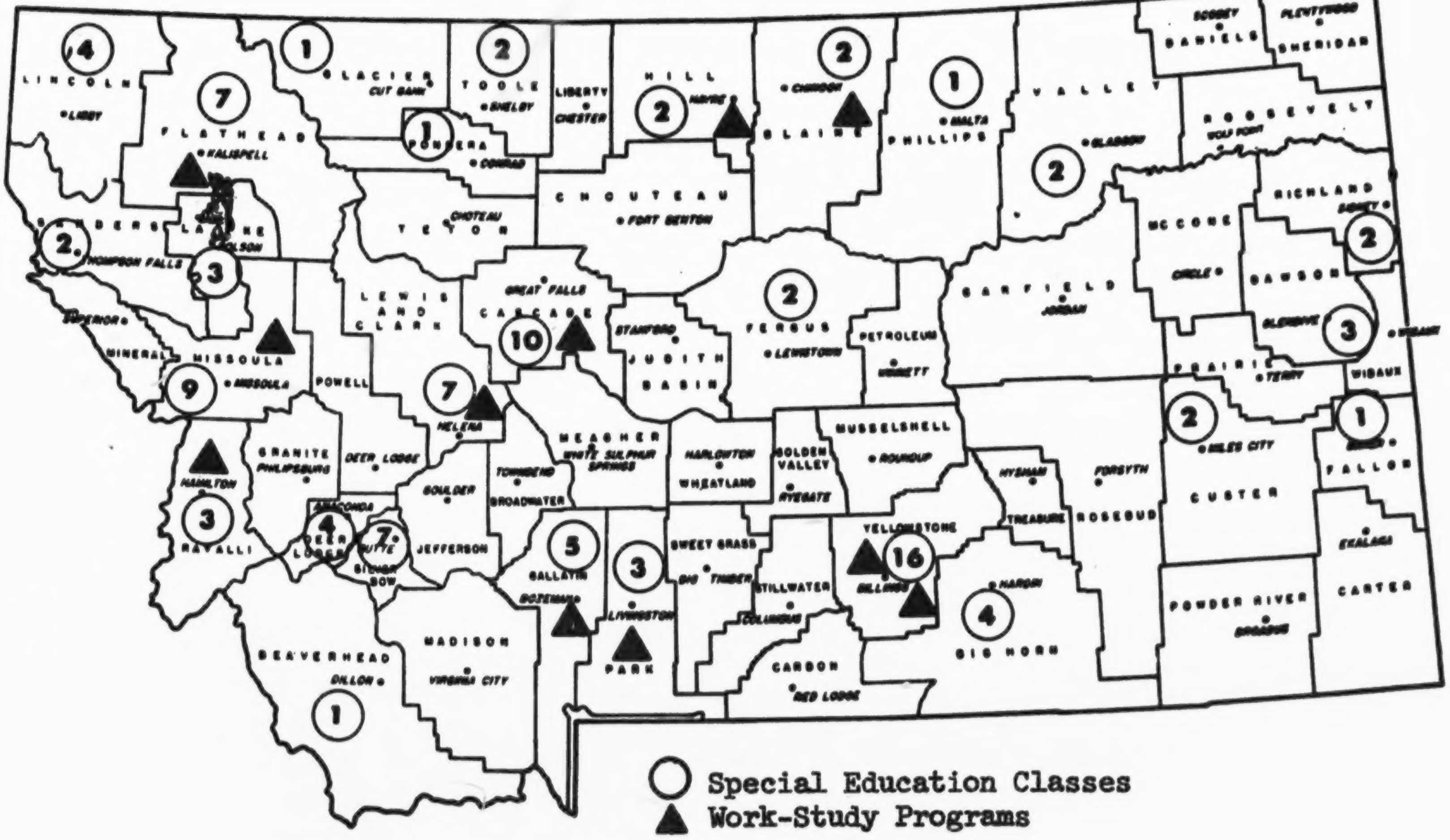
BIG HORN
POWDER RIVER
▲ State Office
● District Offices

MAP 10. INSTITUTIONS



1 - Veteran's Home
2 - Swan River Youth Forest Camp
3 - Mountain View School for Girls
4 - State Prison
5 - Galen State Hospital
6 - Warm Springs State Hospital
7 - Boulder River School and Hospital
8 - Children's Center
9 - School for the Deaf and Blind
10 - Home for the Aged
11 - Pine Hills School for Boys

MAP 11. SPECIAL EDUCATION CLASSES BY COUNTY WORK-STUDY PROGRAMS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BIG HORN
POWDER RIVER
CARTER
Libby
Kalispell
Cut Bank
Shelby
Chester
Havre
Chinook
Malta
Glasgow
Scobey
Plentywood
Wolf Point
Conrad
Choteau
Fort Benton
Great Falls
Stanford
Lewistown
Winnett
Jordan
Circle
Glendive
Sidney
Terry
Miles City
Baker
Thompson Falls
Polson
Superior
Missoula
Helena
White Sulphur Springs
Harlowton
Ryegate
Roundup
Hysham
Forsyth
Hamilton
Philipsburg
Anaconda
Butte
Boulder
Townsend
Bozeman
Livingston
Big Timber
Columbus
Billings
Hardin
Red Lodge
Dillon
Virginia City
Broadus
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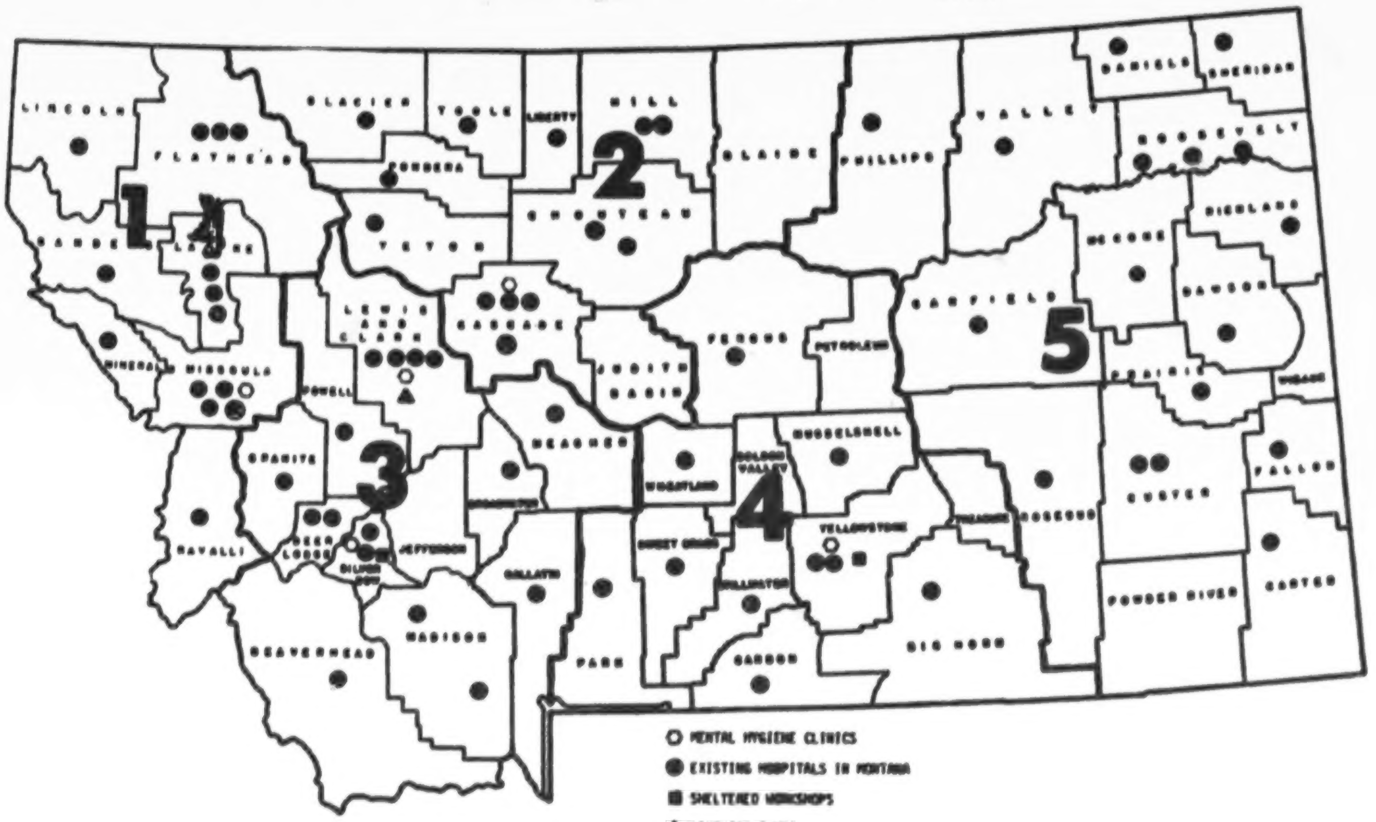
○ Special Education Classes

▲ Work-Study Programs

MAP 12. FACILITIES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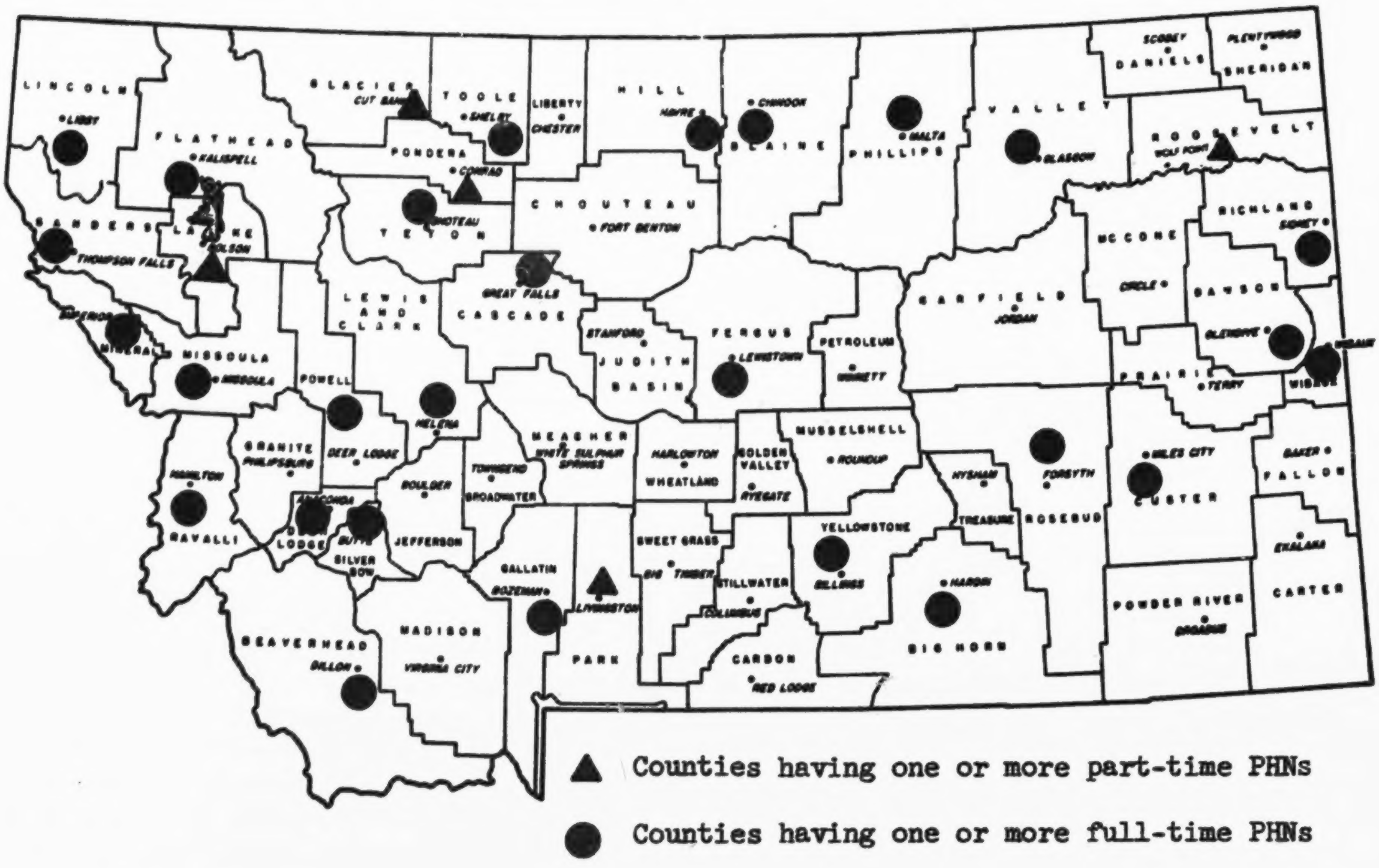
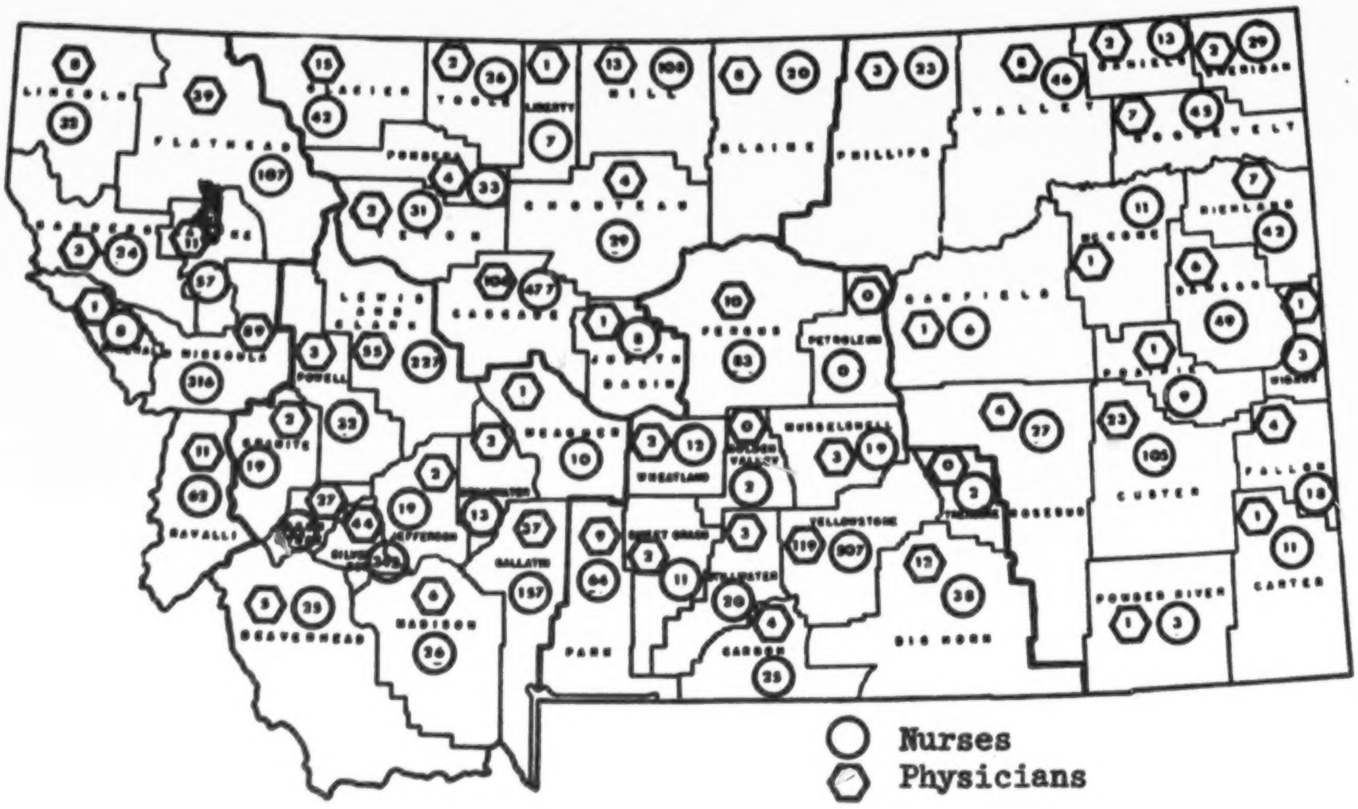
YELLOWSTONE
TREASURE
ROSEBUD
CUSTER
FALLON
BEAVERHEAD
MADISON
PARK
CARBON
BIG HORN
POWDER RIVER
CARTER
○ MENTAL HYGIENE CLINICS
● EXISTING HOSPITALS IN MONTANA
■ SHELTERED WORKSHOPS
▲ HALFWAY HOUSES
● REHABILITATION CENTERS

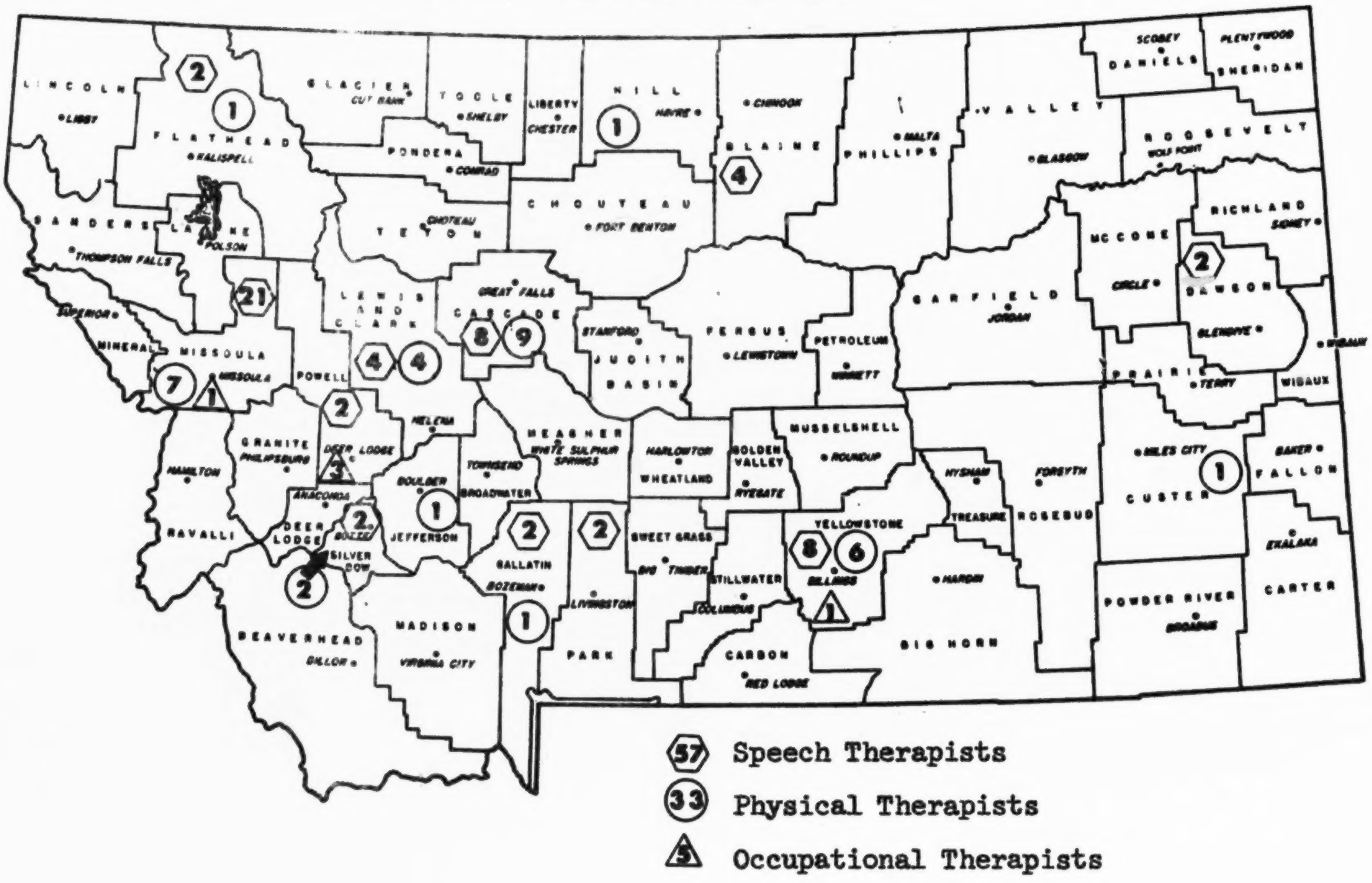
MAP 13. PUBLIC HEALTH NURSES


▲ Counties having one or more part-time PHNs
● Counties having one or more full-time PHNs

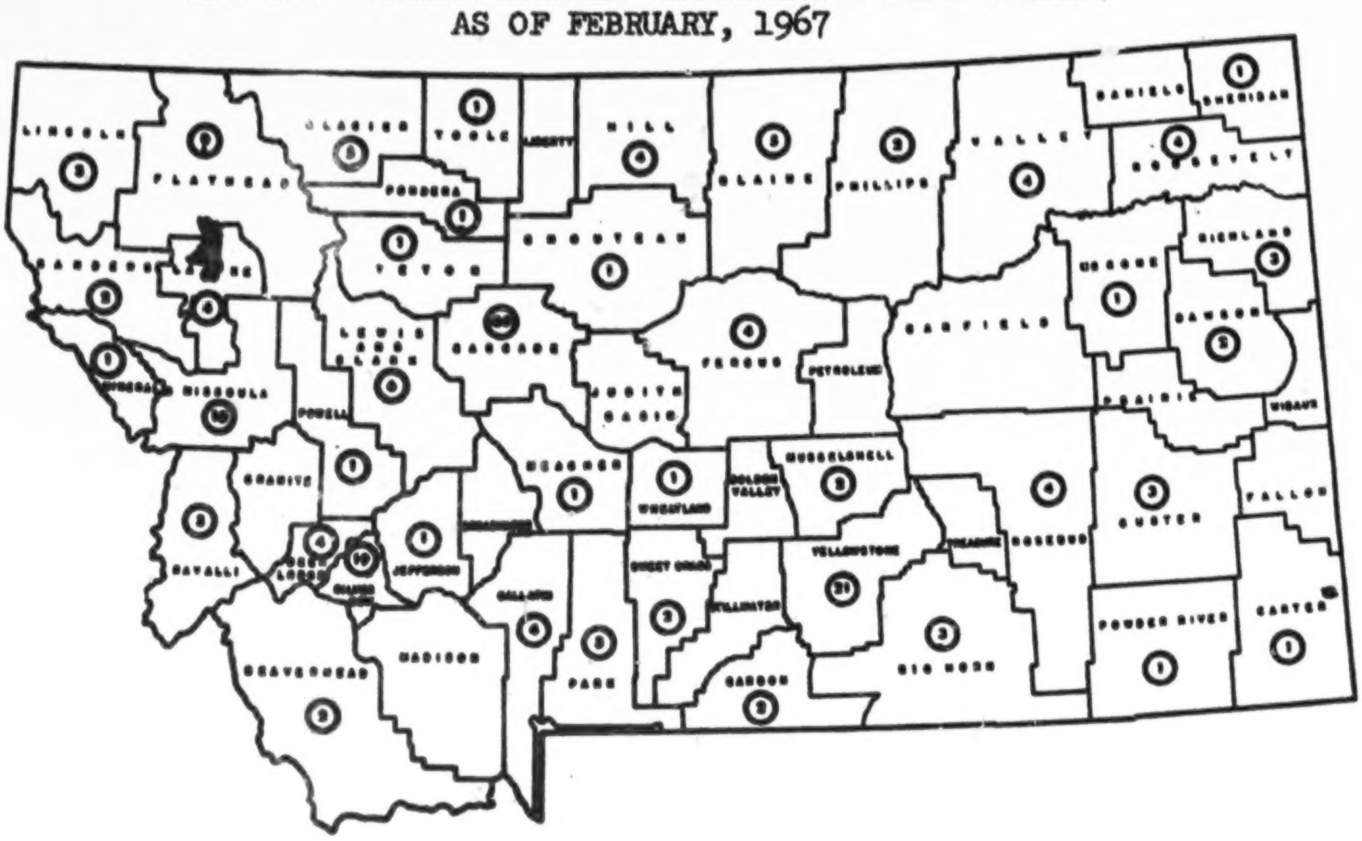
MAP 14. NURSES AND PHYSICIANS


○ Nurses
⬡ Physicians

MAP 15. RESIDENT THERAPISTS


57 Speech Therapists
33 Physical Therapists
5 Occupational Therapists

MAP 16. COUNTY WELFARE DEPARTMENT SOCIAL WORKERS AS OF FEBRUARY, 1967



APPENDIX E

Project Activities

APPENDIX E

Project Activities

Activities of the Project committees and staff were diverse, not only in the work concerned with primary objectives of the program, but in secondary efforts considered necessary to overall success of the study. The dissemination of public information and attempts to create awareness of the needs of the disabled in Montana were the principal secondary goals. Some of these activities are described in this resume.

Project Meetings

Governor's Policy Board

The Policy Board was appointed by the Governor and had overall responsibility for Project direction and determined broad policy. It also reviewed the final Project recommendations, as developed by the working committees. The initial meeting of the Board was held on December 9, 1966. At the time of the final meeting of the group, October 1, 1968, nine meetings had been held, including a two-day session.

Executive Committee of the Policy Board

The Executive Committee, composed of five Policy Board members, served as the functional unit of the Board. Its initial meeting was January 5, 1967, and its final meeting was June 20, 1968. During the intervening period, this group met eight times.

Citizens Advisory Committee

Twenty-five influential and representative groups throughout the state were requested to appoint members to the Citizens Advisory Committee, which provided advice and assistance during the Project. This group reviewed the conclusions of the District Committees and consolidated them into meaningful recommendations with statewide application. The first meeting of the Committee was held March 16, 1967. Subsequent working meetings were held October 20-21, 1967; January 12, 1968; and April 19, 1968.

District Meetings

The Project staff, with approval of the Executive Committee, selected chairmen for each of the 13 planning Districts. The District head then appointed a chairman for each of the 56 counties. An organizational and orientation meeting of District chairmen was held in Helena on May 26, 1967. This meeting was the prelude to a series of two meetings held in each District. The first District meeting in the initial series was held September 11, 1967, and the last on September 22, 1967. The first meeting in the final series was held January 30, 1967, and the last was on March 6, 1968. The first series was devoted to orientation, public information, and survey material dissemination. The second was to report back significant survey results and to accept the responses and recommendations of the counties in each District.

Facilities and Workshops Sub-Committee

Appointments to a Facilities and Workshops Sub-Committee were approved by the Executive Committee on December 21, 1967. The initial meeting of this group was held January 29, 1968. The first full meeting was on March 8, 1968 in Great Falls. The function of the Sub-Committee, composed of persons in administrative or other positions of authority, was to study in depth the need for facilities and to submit recommendations that would coordinate and guide future facility development in Montana. Halfway houses, rehabilitation and treatment centers, and sheltered workshops were the concern of this working committee. Five meetings were held, two that were of two-day duration. The members made visitations to facilities operating both in and out-of-state. National consultants were utilized by this Committee, which also served as the advisory committee to the Facilities and Workshops Project of the Division of Vocational Rehabilitation.

Architectural Barriers Sub-Committee

Appointments to this group were approved by the Executive Committee on December 21, 1967. The first of two meetings was held March 20, 1968, and the final meeting was on June 26, 1968. The function of the Sub-Committee was to assess the architectural barrier legislation in Montana in terms of its overall adequacy and to determine the degree of compliance with the law. The group had charge of suggesting methods by which adherence to the law could be accomplished, and considering the accessibility to the disabled of existing public and private structures.

Governor's Conference on Statewide Planning for Vocational Rehabilitation

A statewide meeting called by Governor Tim Babcock was held in Helena September 30 and October 1, 1968. This conference served as the final meeting of the Project and as the beginning of formal implementation. The statewide recommendations were presented and decisions made as to specific action for implementation of each recommendation.

Project Materials

It was necessary to provide many types of information to the professionals and lay participants in the Project so that meaningful data and recommendations would result from their work. The diverse nature of the Project goals, the orientation toward community involvement, and the necessity to gather data in a uniform manner resulted in the development, by staff, of the following materials.

Rehabilitation Profile of Montana

A 22-page document was provided as background material to all key Project participants. The Profile included Project purposes, parameters of the problems to be considered, demographic information, and available data considered pertinent to committee deliberations.

Glossary

From the beginning of the Project, it was recognized that problems of semantics could result in confusion and wasted energy of the committees as they deliberated and developed recommendations. A standard definition of 47 relevant rehabilitation terms and concepts was provided the committees.

Operational Guidelines

The large number of participants in the Project required standardized procedures for the conduct of meetings, delineation of committee responsibilities, and for other administrative matters as they related to the Citizens Advisory Committee, the District committees, and the county chairmen. A 10-page manual was prepared and distributed for this purpose.

Visual Aids

Flip charts were developed to orient large audiences, in a short period of time, to basic Project objectives, goals, and specific survey methods. These tools were utilized at all District meetings and were instrumental in clarifying many questions concerning procedures.

Rehabilitation - A Shared Burden

A 12-minute narrated slide presentation of the rehabilitative process, as related to three actual clients, was used to create public awareness of the function of Vocational Rehabilitation and the relationship of Statewide Planning to the agencies. This presentation was used at all District meetings and has been utilized for service club and professional audiences.

Statewide Planning Brochure

A pamphlet, "Rehabilitation - A Shared Burden," explaining the the Statewide Planning Project, was mailed to approximately 3000 persons to acquaint them with the program and to invite their participation.

Directory of Facilities and Resources

As a part of the community survey process, county chairmen were asked to inventory rehabilitation-related facilities in each county. This information was compiled into a 19-page document and distributed to Project participants and to many state organizations who requested this listing.

Project Newsletter

As a communication device, periodic newsletters were sent to all participants and to a general mailing list.

Television Spots

Two 60-second television spots were developed and distributed to all Montana stations. These were given public service time prior to the District meetings to assure maximum citizen participation and to promote awareness of the problems of the disabled.

Radio Spots

The Governor, a former Governor, and the Superintendent of Public Instruction presented their views on the need for rehabilitation and planning. These tapes were distributed to all Montana radio stations, and considerable public service time was provided by this media.

News Releases

Throughout the Project, periodic news releases were made to all news media, including daily and weekly newspapers and the wire services. Two interviews regarding rehabilitation needs and Project activities were conducted with Project staff, and were utilized by all large daily papers in the state. In addition, releases of a specialized nature, including the Montana Medical Association, the Montana Chamber of Commerce, the Municipal League, the Catholic Diocese, the Montana Association of Social workers, and others.